PEAKONE administration

HSA ENROLLMENT FORM

Please return this completed form to your HR Department

Participant Information. Please PRINT Clearly.

Employer			Plan Effective Date
Employee's Name (Last, First MI)		Date of Birth	Social Security Number:
Employee's Home Address	City	State	Zip
Employee Email Address			Mobile Phone

As a participant in the employer-sponsored plan, you will receive a free debit card. Debit cards can only be requested for dependents 18 years and older. You can request additional cards online or by contacting our MemberCare Department at membercare@peakoneadmin.com.

Participant card: $0.00
Additional card fee: $0.00
Replacement card fee: $10.00

I request the following amounts to be deducted pretax:

Group Medical Premium If you participate in your employer's insurance plan(s) your premiums will automatically be deducted pre-tax unless you notify your Human Resource Department otherwise.

Reimbursement Sections:	Plan Year Total		# Of Paychecks		$ Per Pay Check
Health Savings Account (HSA) Minimum: $0.00 Individual Max:$4150.00 Family Max: $8300.00		÷		=	

☐ **Yes, I want to enroll.** The IRS regulation states four conditions. 1.) Any expenses you incur must be on or after your effective date 2.) Any expenses you incur must not be covered by any other source such as insurance.

Note: Enrolling may have a minor effect on your social security benefits. Please seek appropriate advice.

You also agree that you will only use the debit card to pay for eligible expenses. You will not use the card for any medical expense that has already been reimbursed. You will also not seek reimbursement under any other health plan for any expense paid for with the card, and the employee will acquire and retain sufficient documentation (including invoices and receipts) for any expense paid with the debit card.

☐ **No, I do not want to enroll.**

Signature: X_____ **Date:** _____