SHDR
Benefit Consultants
A division of McGriff Insurance Services

McGriff Insurance Services

Health Savings Account Application

Instructions

To expedite the enrollment process, please follow these steps:

1. Please print and use blue or black ink only. Do not use pencil.
2. Complete Sections 1 through 5 and sign where indicated.
3. Complete Election and sign where indicated.
4. Return this completed HSA Application to your employer.

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1. Information about you

❑Mr. ❑Mrs. ❑Ms.

First Name | MI | Last Name | SSN

Date of Birth (mm-dd-yyyy)

Mailing Address

City | State | Zip

Telephone (day) (evening) | Email

2. Information about your health plan

You must be covered by an HSA-compatible health plan.

Name of Carrier | Group ID (if applicable)

Subscriber Number | Annual Deductible | Out-of-Pocket Max

Effective Date of Plan (mm-dd-yyyy)

Level of Coverage: ☐ Individual ☐ Family

3. Information about your employer

Name of Company

Date of Hire

4. Information about your dependents

If you have additional dependents, make a copy of this page and continue filling in dependent information. If dependents are minors, you may omit the Social Security Number (SSN).

Name of Spouse | SSN | Date of Birth (mm-dd-yyyy)

Name of Dependent | SSN | Date of Birth (mm-dd-yyyy)

5. Participant contributions

Please indicate the amount of contributions you expect to make for this year (see HSA education material for maximum annual contribution limits). If you wish to roll over an existing HSA to this account, please contact SHDR at 1-800-930-2441.

Annual Employee Contribution **Annual Employer Contribution** **Total Contribution**

$ _____ **$ _____** **$_____**

By signing below, I acknowledge that I understand and meet the eligibility requirements for this type of Health Savings Account. Once the Health Savings Account is opened, SHDR will send me a letter of confirmation along with a copy of the "HSA Custodial Agreement and Disclosure."

Date **Participant Signature**