Health Savings Account (HSA) Plan Set-Up Form

Send completed form via email or fax to:

Email: employers@HealthSavings.com
Fax: (804) 726-1570

Plan Sponsor Information

Company's Full Legal Name _____ Federal Tax ID # _____

Business Type

- ❑ Association/Cooperative
- ❑ C Corporation (C Corp)
- ❑ Joint Venture
- ❑ Limited Liability Company (LLC)
- ❑ Limited Partnership (LP)
- ❑ Non-profit
- ❑ Partnership
- ❑ Professional Corporation (PC)
- ❑ S Corporation (S Corp)
- ❑ Sole Proprietorship
- ❑ Trust
- ❑ Other_____

Does your company have a Section 125 Cafeteria Plan?

❑ Yes ❑ No ❑ I Don't Know

Physical Address_____

City _____ State _____ ZIP _____

Mailing Address (If different from physical address)_____

City _____ State _____ ZIP _____

Phone Number _____ Fax _____

Website_____ Total # of Employees_____ Payroll Services Provider_____

Main Administrator

Please provide contact information for your company's main administrator. The main administrator will have access to the employer portal and will be responsible for reviewing transactions, including but not limited to verifying the accuracy of plan contributions. The main administrator also authorizes other administrative users and assigns permissions for accessing and/or updating the plan.

First Name_____ Last Name _____ M.I._____

Title_____ Phone _____ Email _____

Privacy, the USA PATRIOT Act and the Employer Site — We respect the confidentiality of customer information. Some of the information we request is required by the USA Patriot Act and regulations adopted by governmental agencies to implement it. This law requires us to obtain, verify and record information that identifies each person or entity that opens an account. This information helps the government fight the funding of terrorism and money laundering activities. When signing up for the employer portal, we will ask for your company's name and address. We will also ask for an identification number such as your Social Security, EIN or Tax Identification number. This information will allow us to identify you. In some instances, we may also ask to see identifying documents. Rest assured that all customer information is kept in the strictest confidence, unless required by law to be disclosed.

FPS Trust (Custodian) and *HealthSavings* are not responsible for any loss, injury or damage, whether direct, indirect, special, consequential, exemplary, economic or otherwise, caused by the use of the website or the unauthorized access of the website. The plan sponsor shall be solely responsible for requesting a password to be used by authorized users. Plan sponsor shall be solely responsible for the protection of such passwords to ensure that only authorized users access the website. Plan sponsor shall ensure that all authorized users comply with the terms and conditions of this agreement and shall be solely responsible for any failure by the authorized users to do so. Because the provided password can be used to access sensitive account information, all authorized users should treat the password with the same degree of care and confidentiality that they use to protect other sensitive financial data. All authorized users agree to not give the password or make it available to any person not authorized to access the website. Further, plan sponsor agrees to notify *HealthSavings* immediately should any previously authorized user become ineligible for access, so that the password may be deactivated.

HealthSavings Administrators Employer Services | 10800 Midlothian Tpke, Ste 240, Richmond, VA 23235 | (p) (888) 354-0697 | (f) (804) 726-1570

Health Savings Account (HSA) Plan Set-Up Form

Secondary Administrator *(if desired)*

Subject to the terms and conditions of the agreement, the Plan Sponsor may authorize a secondary administrator to act in the capacity of the main administrator. If additional administrators are needed, please provide that information on a separate page.

First Name_____ Last Name _____ M.I._____

Title_____ Phone _____ Email _____

Billing Contact *(if applicable)*

If the main administrator is not the contact for billing, please provide information for the person we should contact regarding billing.

First Name_____ Last Name _____ Title _____

Billing Address (If different from physical address above) _____

City _____ State _____ ZIP _____

Phone_____ Fax_____ Email _____

Health Insurance Broker/Consultant *(if applicable)*

First Name_____ Last Name _____ Company_____

Phone_____ Email_____ Website_____

Financial Advisor/Professional *(if applicable)*

First Name_____ Last Name _____ Company_____

Phone_____ Email_____ Website_____

HSA RIA fee *(if applicable)*: _____

Plan Information

High deductible health plan (HDHP) effective date_____ # of participants electing HDHP (est.)_____

Health savings account (HSA) start date _____ HSA annual administrative fee: _____

Who pays the administrative fee and when?

❑ Plan Sponsor > Invoiced monthly* ❑ Participant > Deducted from account annually

*If the Plan Sponsor pays the administrative fee, the Plan Sponsor is responsible for notifying *HealthSavings* when employees terminate employment. Failure to notify *HealthSavings* may result in payment of administrative fees for terminated employees.

Preferred investment program: _____

HSA custodial fee**: ❑ 6.25 basis points per quarter ❑ Other: _____

**Custodial fee is based on the choice of investment program. Please refer to the investment program's fee disclosure for details.

How frequently will contributions be made to participants' HSAs?

❑ Per pay period ❑ Monthly ❑ Quarterly ❑ Semi-annually

❑ Annually ❑ Never

Preferred enrollment method *(select one):*

❑ Eligibility file upload ❑ Pre-registration with online enrollment ❑ Online enrollment

Preferred funding method *(select one):*

❑ ACH pull ❑ ACH push or wire ❑ Check ❑ Direct deposit

HealthSavings Administrators Employer Services | 10800 Midlothian Tpke, Ste 240, Richmond, VA 23235 | (p) (888) 354-0697 | (f) (804) 726-1570

Health Savings Account (HSA) Plan Set-Up Form

Prior HSA Provider Information *(if applicable)*

Company Name _____

Contact First Name _____ Contact Last Name_____

Address_____

City _____ State _____ ZIP _____

Phone _____ Fax _____ Email _____

Website _____

Additional Terms *(if applicable)*

HealthSavings Administrators Employer Services | 10800 Midlothian Tpke, Ste 240, Richmond, VA 23235 | (p) (888) 354-0697 | (f) (804) 726-1570

Health Savings Account (HSA) Plan Set-Up Form

Signatures

***HealthSavings* Administrators, LLC**

Authorized Signer Name *(printed)* W. Patrick Jarrett Title President

Address 10800 Midlothian Tpke, Ste 240

City Richmond State VA ZIP 23235

_____ _____ / _____ / _____

Signature Date *(mm/dd/yyyy)*

Plan Sponsor

Authorized Signer Name *(printed)* _____ Title _____

Address _____

City _____ State _____ ZIP _____

_____ _____ / _____ / _____

Signature Date *(mm/dd/yyyy)*

FOR OFFICE USE ONLY

Sales Director _____

Employer Liaison _____

Channel Code _____

Alliance Code _____

Form Distributed to: ❑ HSAA ❑ FPS

HealthSavings Administrators Employer Services | 10800 Midlothian Tpke, Ste 240, Richmond, VA 23235 | (p) (888) 354-0697 | (f) (804) 726-1570