

ALERUS

HEALTH SAVINGS ACCOUNT ENROLLMENT FORM - GROUP

Employer Name _____ Division _____

INSTRUCTIONS

- Complete this form in order to open an HSA. (* = Required Fields)
- Submit completed pages 1 and 2 to your human resources department.
- If you have any questions regarding this form, call us at **877.661.4727** or email healthbenefits@alerus.com.

ACCOUNTHOLDER INFORMATION

*Last Name		*First Name		*Middle Initial		*Social Security Number			
*Employee ID				*Email Address					
*Address Line 1 (Cannot be P.O. Box)				*Address Line 2 (Cannot be P.O. Box)					
*City		*State		*ZIP					
*Home Phone		*Daytime Phone Number		*Date of Birth		*Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		*Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	
*Mother's Maiden Name		*Hire Date		*Hours Worked Per Week		*Payroll Frequency			

ELECTION

I am enrolling in an HSA through my employer. I authorize my employer to deduct my HSA contributions from my pay and forward them to my HSA. (Please complete the section immediately below.)

Note: Your employer may also make a contribution to your HSA that will apply to your maximum contribution allowed. You are solely responsible for determining whether contributions to an HSA exceed the maximum annual contribution limitation. You are also responsible for notifying the custodian of any excess contribution and requesting a withdrawal of the excess contribution together with any net income attributable to the excess contribution.

*Indicate an annual employee election **OR** a pay period election: **Employee Annual Contribution** **Per Pay Period Contribution**
\$ _____ OR \$ _____

*Indicate HDHP Coverage Level: Self-Only OR Family/Other

*Indicate if you are enrolled in an HDHP through your employer: Yes OR No

HSA Enrollment Effective Date _____ | _____ | 20 _____

Your contributions will be withdrawn from your pay in each pay period. If your employer maintains a cafeteria plan that permits HSA contributions, your contributions will be made with pre-tax dollars. You may also make contributions outside of your employment. If you would like to make a contribution immediately, please complete an HSA Contribution Form and submit that form with your payment.

REIMBURSEMENT METHOD

Please select your primary method of payment for distributions requested from your HSA. (You will receive a debit card for your HSA. This reimbursement method is for manual distribution requests only.)

- Direct Deposit** – You will need to provide your bank account information in the Direct Deposit Setup section.
OR
 Check – All reimbursements paid by sending you a check. Note that a fee of **\$0.50** will apply for each check reimbursement. If choosing this option, skip the Direct Deposit Setup section.

DIRECT DEPOSIT SETUP

This section is required if you have chosen Direct Deposit as your HSA Reimbursement Method above.

*Bank Name			
*Address	*City	*State	*ZIP
*Account Type <input type="checkbox"/> Checking <input type="checkbox"/> Savings		*Routing Number	*Account Number

BENEFICIARY DESIGNATION AND INFORMATION

I designate the following individual(s) or entity as my primary or contingent death beneficiary(ies) of this HSA. If I am married in common law or in a community or marital property state, I must designate my spouse as my Primary Beneficiary unless spouse’s signature is obtained and notarized below. Share percentages must equal 100 percent for primary and 100 percent for contingent.

No.	Name and Address	Date of Birth	Social Security Number	Primary or Contingent	Relationship	Share %
1.				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	
2.				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	
3.				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	

Please check on of the following:

- I am not married and I understand that if I become married in the future, I must complete a new Beneficiary Designation Form.
- I am married and I understand that if I choose to designate a primary death beneficiary other than my spouse, my spouse must agree to the designation by signing below. **My spouse’s signature must be notarized.**

Signature of Spouse	Subscribed and sworn to before me this _____ day of _____, 20 _____
Date	Notary Public

SIGNATURE

I certify that the information provided by me on this Enrollment Form is accurate. I assume sole responsibility for all consequences found in the Enrollment Form. I understand that I may revoke the HSA on or before the seventh day after the date of establishment. I have not received any tax or legal advice from Alerus, and I will seek the advice of my own tax or legal professional to ensure my compliance with related laws. I release and agree to hold the Alerus harmless against any and all claims or losses arising from my actions.

I hereby further agree to designate the TPA to serve as my Designated Representative with respect to my HSA account.

Signature of HSA Accountholder	Date
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