HSA Employer Group Enrollment Application

To be completed by the employer and/or licensed agent when requesting Health Savings Account services.

Please select one: ☐ New or ☐ Renewal

EMPLOYER INFORMATION

Employer name ____ Employer tax ID number ______________________

Employer main office address 1 ____

City ____ State __________ ZIP ________________

Employer Additional Address ____

City ____ State __________ ZIP ________________

____

ENROLLMENT INFORMATION

Method of enrollment (must select one of the following as the primary enrollment): Paper ☐ Portal ☐ Electronic ☐

HSA Plan Start Date _______________________

All employment changes must be submitted to Flex@Insurapath.com

____

CONTRIBUTIONS

Will the employer be contributing to the employee's Health Savings Account? Yes ☐ No ☐

Note: Please complete and return the attached payroll deduction calendar.

If yes, employer contribution schedules: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Annual

Employer contribution amount: $_______________

____

EMPLOYER CONTACT INFORMATION

Primary Employer Contact ____ Phone _____________________

Email ____

Secondary Employer Contact ____ Phone _____________________

Email ____

Date __________________ Print Name ____

Authorized Employer Signature, Title ____

Fax or mail completed form to:

Insurapath, Inc. 5300 S Broadband Lane Sioux Falls, SD 57108
Phone: 605-322-4774 Fax: 605-504-9305 Email: Flex@Insurapath.com