SelectAccount®

HEALTH SAVINGS ACCOUNT APPLICATION

Employer offered HSA **BLaST Intermediate Unit 17**

Account Holder's Information

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Primary Phone: _____

SSN#: _____ Date of Birth: _____

Health Insurance Plan Information

Type of High Deductible Health Plan Coverage:

☐ Single
☐ Non-Single

Effective Date of Health Insurance Plan _____

Per Pay Deduction Amount: _____

Signature

The Account Holder named above is establishing this health savings account (HSA) exclusively for the purpose of paying or reimbursing qualified medical expenses of the account holder, his or her spouse, and dependents. The account holder represents that, unless this account is used solely to make rollover contributions, he or she is eligible to contribute to this HSA; specifically, that he or she: (1) is covered under a high deductible health plan (HDHP); (2) is not also covered by any other health plan that is not an HDHP (with certain exceptions for plans providing preventive care and limited types of permitted insurance and permitted coverage); (3) is not entitled to benefits under Medicare (generally, has not reached age 65); and (4) cannot be claimed as a dependent on another person's tax return. It is my responsibility to determine whether contribtions to this HSA have exceeded the applicable maximum annual contribution limit. For current eligibility guidelines and contribution limits, go to **www.SelectAccount.com.**

_____ _____

HSA Account Holder Signature Date