Special Notes:

HEALTH SAVINGS ACCOUNT (HSA)

ENROLLMENT FORM/CHANGE OF STATUS

* Indicates a required field – Must be completed to process enrollment

* **Employer Name:**	**COMPANY ID: CHO**
* Effective Date of Enrollment:	* Date of Hire:
* First Name: MI:	* Last Name:
* Mailing Address:	Mailing Address 2:
* City:	* State: * Zip Code:
* Phone #: Cell Phone #:	* Email:
* Social Security #: ☐ ☐ ☐ - ☐ ☐ - ☐ ☐ ☐ ☐	* Date of Birth: * Gender:

Eligible Dependents to be covered on the HSA:

* First Name	* Last Name (if different)	MI	* Relationship	Sex *(M/F)	* Date of Birth	* Social Security Number	Full Time Student?

To activate your Health Savings Account so that you can deposit and distribute funds, please completely fill out this form. All forms MUST be printed and legible. NOTE: Any form that is illegible or not completely filled out will be returned. Please read the Deposit Agreement & Disclosure Statement before completing this enrollment.

Request for Tax Certification Under penalties for perjury, I certify that the SSN number shown on this form is my correct taxpayer identification number and I am a citizen or resident of the United States. The IRS does not require you to consent to any provision of this document.

By signing this form I hereby authorize The Bank of New York Mellon. (the "Bank") to establish a Health Savings Account on my behalf. I acknowledge that I have received and read a copy of the "The Bank of New York Mellon Deposit Agreement & Disclosure Statement". I agree: (a) To be bound by the Deposit Agreement & Disclosure Statement applicable to the Health Savings Account established by this form, as the agreement may be amended from time to time; (b) To be bound by the Bank's agreements and Disclosures applicable to any additional accounts that I may establish with the Bank in the future as an individual, custodian, or single trustee.

This agreement will remain in effect as long as I continuously maintain at least one covered account with the Bank.

* **I elect to participate in *The Choice Care Card*™**		**I *do not* elect to participate in *The Choice Care Card*™**
☐ Mail me a check via US postal service ☐ Directly Deposit into my checking or savings account Direct Deposit (ACH): When filing claims manually, I hereby Authorize The Choice Care Card to Credit the amount indicated below: Account Number: ________________________________ Routing Number (9 digits): ________________________ Type of Account: ☐ Checking ☐ Savings		

By signing below I hereby authorize the release of claim information to my employer, their broker, and *The Choice Care Card*™ administrator.

* **Employee Signature**: ____ **Date:** ________________________________

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