Health Savings Account (HSA) Enrollment Form

Consumer Driven Healthcare (CDH)

REHN & ASSOCIATES

INSTRUCTIONS

1. Complete this two-page form to open an HSA. **(* = Required Fields)**
2. Return completed document to your Human Resources or Payroll Department.
3. If you have any questions regarding this form, please call (800) 872-8979 or emails us at RehnCDH@rehnonline.com.

Part I - Accountholder Profile Information

***Consumer Name** First, MI, Last		***Employer Name**	
***Birth Date** MM/DD/YYYY	***Social Security Number** XXX-XX-XXXX	***Home Phone** (XXX) XXX-XXXX	***Mobile Phone** (XXX) XXX-XXXX
***Mother's Maiden Name**		***Email Address**	
***Physical Street Address** (*U.S. physical address required to open an HSA*)			
***City**		***State**	***Zip Code**
Alternate Mailing Street Address or PO Box			
City		State	Zip Code
***Gender** Male ☐ Female ☐ Unspecified ☐		***Marital Status** Married ☐ Single ☐	
***HSA Effective Date** MM/DD/YYYY	***Employer Hire Date** MM/DD/YYYY	***Payroll Frequency**	

Part II - Authorization and Eligibility Certification

When opening an HSA with Rehn & Associates CDH Department, I understand and agree to the following:

- **I am a resident of the United States of America.**
- **I am at least 18 years old and cannot be claimed as a dependent on someone else's tax return.**
- **I am covered under a high deductible health plan (HDHP).**
- **I am not enrolled in Medicare.**
- **I am not enrolled in TRICARE.**
- **I do not have any other non-qualified health coverage.**
- **I do not have a Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRA) to pay for medical expenses incurred before my medical plan deductible is met, unless it is limited to pay for dental and vision expenses only.**
- **My spouse, if applicable, does not have a Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRA) to pay for medical expenses before their medical plan deductible is met, unless it is limited to pay for dental and vision expenses only.**

***Signature**	***Print Name**	***Date**

Typed signatures will not be accepted without an accompanying e-signature verification of authenticity. Handwritten signatures will be accepted without issue.

As a follow-up to this application and upon receiving your enrollment confirmation, you will need to login to the HSA website to accept your terms and conditions.

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Part III - Election for Payroll Deduction
(Complete this section if you are enrolling through your employer's benefit offering)

☐ **I authorize my employer to deduct my HSA contributions from my payroll and forward them to my HSA.**

My health plan coverage Type: **Single** ☐ **Family** ☐

Note – The HSA has a maximum annual contribution limit that is determined by your health insurance coverage (self-only/family). Your employer may choose to contribute to your HSA, which will count towards to your maximum contribution allowed. Your health plan eligibility determines the effective date of your HSA. If you are covered on December 1, you are considered eligible for the entire year and not required to pro-rate your contributions. If you cease to be an eligible individual during the next calendar year, any contributions over the prorated amount may be an excess contribution. You are solely responsible for determining whether contributions to your 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. For additional information regarding eligible and contribution limits please go to: www.irs.gov.

2023 Annual Contribution Limit				**2024 Annual Contribution Limit**		
Health Plan Coverage Level	*Annual Contribution Limit	Per Month		Health Plan Coverage Level	*Annual Contribution Limit	Per Month
Self-Only	$3,850	$320.83		Self-Only	$4,150	$345.83
Family	$7,750	$645.84		Family	$8,300	$691.66

*Age 55+ eligible for an additional catch-up contribution of $1,000

Your Personal Contribution Election

Annual Maximum Contribution (plus catch-up if eligible)	Minus (-)	Total Employer Annual Contribution	Equals (=)	Your Eligible Annual Contribution	Divide (/)	Number of Payrolls per Year	Equals =	**Your Maximum Per Pay Period Payroll Deduction**
$ _____		$ _____		$ _____		_____		$ _____

Please withhold **$** _____ from my payroll and apply to my Rehn & Associates CDH HSA.

Part IV - Debit Card

A debit card will automatically be issued to you to use to make medically qualified purchases from your HSA account.
If you do not wish to have a debit card, then please select below.

☐ I do NOT wish to have a debit card with my HSA.

Part V - Bank Account and Reimbursement Method

When I am not using my debit card and request a distribution through the HSA website, then I select the method below to automatically to receive my HSA distributions.

☐ **Paper Check** – I wish to have a paper check mailed to me. [I understand there may be a per check fee of **$1.50**].

OR

☐ **FREE Direct Deposit** – I wish to have distributions automatically deposited into my personal bank account and will complete the Direct Deposit Setup below. This personal bank account can also be utilized to make a post-tax contribution to your HSA from the HSA website and the HSA mobile application.

Next Steps:

1. Email, mail or fax completed form to your employer.
2. **Upon receiving enrollment confirmation, log into the HSA Portal and accept the terms & conditions of the HSA.**
3. Verification of my identity is required for opening an HSA and may result in needing to supply additional information. If this applies to me, I will be notified by my employer on how to proceed.

Rehn & Associates CDH Department
PO Box 5433 | Spokane, WA 99205
Phone: (800) 872-8979 | Fax: (509) 535-7883 | Email: rehncdh@rehnonline.com

HSA Beneficiary Designation Form

Consumer Driven Healthcare (CDH)

Use this form to request a beneficiary for your HSA.

If you want to designate a primary beneficiary other than your spouse, and you live in a community property state (for example AK, AZ, CA, ID, LA, NV, NM, TX, WA or WI), your spouse must agree in writing to your designation, and you must submit a physical copy of this form. Designations are effective upon receipt by Rehn & Associates CDH Department and, unless otherwise specified, cancel all previous HSA beneficiary designations on file.

INSTRUCTIONS

1. Complete all sections of this form. **(* = Required Fields)**
2. Email, mail, or fax completed form to Rehn & Associates CDH Department.
   a. Email: rehncdh@rehnonline.com
   b. Address: PO Box 5433 | Spokane, WA 99205
   c. Fax: (509) 535-7883
3. If you have any questions regarding this form, please call (800) 872-8979 or emails us at RehnCDH@rehnonline.com.

Part I Consumer Information

* **Consumer Name** First, MI, Last		*Employer Name	
*Birth Date MM/DD/YYYY	*Social Security Number XXX-XX-XXXX	*Home Phone (XXX) XXX-XXXX	*Mobile Phone (XXX) XXX-XXXX
*Mother's Maiden Name		*Email Address	
*Physical Street Address (*U.S. address required to open an HSA*)			
*City		*State	*Zip Code

Part II Consumer Authorization / Marital Status

*Consumer Signature	*Print Name	*Date

Typed signatures will not be accepted without an accompanying e-signature verification of authenticity. Handwritten signatures will be accepted without issue.

I hereby give the HSA Beneficiary any interest I have in the funds or property deposited in this HSA and consent to the beneficiary designation(s) indicated above. I assume full responsibility for any adverse consequences that may result. I acknowledge that this form may be electronically signed (if no spouse signature is required) and I agree that the electronic signature appearing on this document is the same as handwritten signatures for the purpose of validity, enforceability and admissibility.

☐ **I am not Married** – I understand that if I become married in the future, I must complete a new HSA Beneficiary Form.

☐ **I am Married** – I understand that if I choose to designate a primary beneficiary other than my spouse, my spouse must sign below. ***

*Spouse Signature	*Print Name	*Date

Typed signatures will not be accepted without an accompanying e-signature verification of authenticity. Handwritten signatures will be accepted without issue.

****I am the spouse of the above-named HSA Account Holder. I acknowledge that I have received a fair and reasonable disclosure of my spouse's property and financial obligations. Due to the important tax consequences of giving up my interest in this HSA, I have been advised to see a tax professional.*

HSA Beneficiary Designation Form

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Part III Designation of Beneficiary(ies)

- If neither the primary nor contingent beneficiary is indicated, the individual or entity will be deemed to be the primary beneficiary.
- If any beneficiary dies before me, his or her interest shall terminate completely, and the percentage of any remaining death beneficiary(ies) shall be increased on a pro rata basis.
- If more than one primary beneficiary is designated and no distribution percentages are indicated, the death beneficiaries will be deemed to own equal share percentages in the HSA.
- Multiple contingent death beneficiaries with no share percentage indicated will also be deemed to share equally.
- If no primary death beneficiary(ies) survives me, the contingent death beneficiary(ies) shall acquire the designated share of my HSA.
- If you designate your spouse as primary death beneficiary or contingent death beneficiary of the HSA, the dissolution, termination, annulment or other legal termination of your marriage will automatically revoke such designation.

Beneficiary #1

Share percentages must equal 100% for primary and 100% for contingent if adding multiple beneficiaries.

* **Full Name** (or Trust and Trustee Name)	☐ Primary ☐ Contingent	***Share %**
***Birth Date** MM/DD/YYYY (or Trust Creation Date)	***SSN** XXX-XX-XXXX (or Trust TIN)	***Relationship**
***Address**		
***City**	***State**	***Zip Code**

Beneficiary #2

Share percentages must equal 100% for primary and 100% for contingent if adding multiple beneficiaries.

* **Name** (First, MI, Last)	☐ Primary ☐ Contingent	***Share %**
* **Birth Date** (MM/DD/YYYY)	***Social Security Number** XXX-XX-XXXX	***Relationship**
***Address**		
***City**	***State**	***Zip Code**

Beneficiary #3

Share percentages must equal 100% for primary and 100% for contingent if adding multiple beneficiaries.

* **Name** (First, MI, Last)	☐ Primary ☐ Contingent	***Share %**
* **Birth Date** (MM/DD/YYYY)	***Social Security Number** XXX-XX-XXXX	***Relationship**
***Address**		
***City**	***State**	***Zip Code**