

Employer Signup Form



Instructions: All fields are required unless otherwise noted. Please complete this form using your computer or print clearly.

- Signing up through an agent or broker – please provide the Agent Identification Number (AIN)*: _____
- Signing up without an agent or broker

*If you are unable to obtain the AIN, please have your agent or broker contact our Business Relations team at 866-357-5232. Upon completion, please submit this form to HSA Bank by mail to P.O. Box 939, Sheboygan, WI 53082; fax to 920-803-4184; or email to hsaforms@hsabank.com. If you have questions, please contact us at 866-357-5232, Monday through Friday, 7 a.m. to 7 p.m. CT.

Company Information			
Company Name:		Employer Federal Tax ID#:	
Address:		P.O. Box:	
City:	State:	ZIP:	
Phone:	Fax:	Company URL:	
Number of Employees:	Number of Employees Electing an HSA:	Effective Date of HDHP (mm/dd/yyyy):	
Number of Benefit Eligibles:	Payroll Schedule: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Other		
Do you want participants assigned to divisions for reporting purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please provide a primary contact for divisions.)			
Primary Contact Information			
The Primary Contact is the only individual who will have full administrative rights. If you wish to change your Primary Contact in the future, you must complete an Employer Change Form, which can be requested by calling Business Relations at 866-357-5232.			
First Name:		Last Name:	
Phone:	Extension:	Fax:	
Email:			
<i>HSA Bank will provide you with login information to access the Employer Administration Site.</i>			
Is the Invoicing Contact the same as the Primary Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<i>* If your Primary Contact and Invoicing Contact are not the same, please provide the Invoicing Contact's information below.</i>			
Invoicing Contact Information (HSA Bank will provide you with login information to access the Employer Administration Site.)			
First Name:		Last Name:	
Phone:	Extension:	Fax:	
Email:			
Permissions Based on Title (If Granted Employer Portal Access)			
Primary Contacts: Access to employee data* and reporting, as well as the ability to import demographic, enrollment, and contribution files			
Invoicing Contacts: "View only" access to employee data and reporting			
*Employee data includes name, address, date of birth, marital status, gender, last four digits of Social Security number, username, employment information, and total employer contributions.			
Setup Preferences			
For information on your options, visit www.hsabank.com , select the Employer tab, and click on Determine Enrollment Method or Select Contribution Options. Additional information will also be included in your Welcome Email and Employer Manual. If you would like to change your enrollment method, please call Business Relations at 866-357-5232.			
Would you like to be invoiced for your employees' monthly fees?* <input type="checkbox"/> Yes <input type="checkbox"/> No			
<i>*Term of the final negotiated contract, if applicable, would govern.</i>			
Welcome Kit Code:		First Payroll Date:	
Please complete all that apply.			For HSA Bank Use Only
Health Plan Code:	AIN:	Marketing:	BP ID:
Service Code:	Broker Dealer:	TPA:	MGA:

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AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

I hereby authorize HSA Bank , hereinafter called BANK, to initiate debit entries to COMPANY's Checking Account/ Savings Account (select one) on file with BANK or indicated in the banking information section of this form, hereinafter called DEPOSITORY, and to debit the same to such account for payment of the monthly invoiced Health Savings Account service fees for our employees. (An email notification will be sent to you with online access to your invoice at least 8 days in advance of your monthly scheduled payment dates. Your monthly invoices and employee list will be available online at the Employer Administration Site.) I acknowledge that the origination of ACH transactions to COMPANY's account must comply with the provisions of U.S. law.

Banking Information		
Depository Name:	Branch:	
Address:	Phone:	
City:	State:	ZIP:
Routing Number:	Account Number:	
Type of Account: <input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account		

Authorization	
The authorization is to remain in full force and effect until the BANK has received written notification from me (or either of us) of its termination in such time and in such manner as to afford BANK and DEPOSITORY a reasonable opportunity to act on it.	
Name(s):	Title:
Signature:	Date:
NOTE: ALL WRITTEN DEBIT AUTHORIZATIONS MUST PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.	