

Revised 10/2021

Reason for completing form:

New Enrollment Changing contribution amount Change in family status Cancellation

Employer Information

Enrollment cannot be processed without your employer's name.

Employer name:

Account Holder Information

First name:	M.I.:	Last name:	
SSN:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (mm/dd/yyyy):	
Email address:		Preferred phone:	
Physical street address:	City:	State:	ZIP:
Mailing address (if different):	City:	State:	ZIP:

Health Insurance Coverage

Insurance carrier: **West Virginia Public Employees Insurance Agency (PEIA) PPB Plan C**

Coverage type:
 Single Family

Authorization and Certification

By opening a health savings account (HSA) with HealthEquity, you accept the terms of HSA enrollment and the custodial agreement. You may view the [HSA custodial agreement](#). Upon enrollment, you understand and agree to the following:

- You are covered by a qualified high deductible health plan (HDHP).
- **You are not covered by any other non-qualified health coverage, including Medicare Part A and Part B.**
- You are not claimed as a dependent on another individual's tax return.
- HealthEquity must verify your identity in order to open your HSA.

For further information regarding HSA laws, go to <https://www.irs.gov/pub/irs-pdf/p969.pdf>

Print name: X	Signature: X	Date: X
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Contribution Information and Authorization Frequency of payroll: **Bi-Weekly**

Please withhold \$ _____ from every pay **Date to begin deduction:** Immediately or Date: _____ Do you wish to participate in the Age 55 catch-up? Yes No

Signature: X	Date: X
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2022 annual HSA contributions

2022 HSA age 55 catch-up

Coverage type	Total annual contribution
Self-Only	\$3,650
Family	\$7,300

Coverage type	Total annual contribution
Self-Only	\$1,000
Family	\$1,000

Your HSA cash balance is held at an FDIC-insured or NCUA-insured institution and is eligible for federal deposit insurance, subject to applicable requirements and limitations.

Return this form to your campus
Benefit Coordinator

Human Resources Use Only:

Signature: _____ Date: _____

Effective Date of First Deduction: _____