



Health Savings Account (HSA) Enrollment with Streamline Option

Instructions

- Retain copies for your files.
- Please submit completed form to your employer.

Account Holder Information

Social Security Number	Name (Last, First, MI)	Home Telephone Number	Business Telephone Number
Address (Street, City, State and Zip Code)			Birthdate (MM/DD/YYYY)
Employer Name			

Authorization

I authorize the reduction of my salary from my paycheck based on the total annual contribution amount.

I also understand that if I choose to change the contribution amount, I need to submit a change in contribution form to my employer.

Signature _____ Date _____

Streamline Option

I request that Aetna does not pay for any expenses out of my HSA account unless I submit a written request for disbursement.

I request Aetna to automatically pay my medical expenses out of my HSA if the expenses are not eligible to be paid under my HDHP. By my signature below, I hereby request reimbursement for all expenses, from my Health Savings Account for the entire plan year. I understand that any/all amounts not reimbursed under my benefits plan will automatically be paid from my Health Savings Account for each claim submitted by the provider of service or myself. I certify that neither I nor any of my dependents have any other health coverage and that the expenses automatically reimburse will not be submitted for payment under any other plan. I further declare that I will not deduct these expenses on my federal income tax return.

Signature _____ Date _____

Direct Deposit Authorization

I accept my Health Savings Account withdrawal to be directly deposited from my HSA to my checking or savings account. (Please complete the Authorization Direct Deposit Form)

I reject my Health Savings Account withdrawal to be directly deposited from my HSA to my checking or savings account and prefer to receive payment via check.

Initial Contribution Amount

Please designate the annual amount you wish to contribute to your Health Savings Account this year.

Employee Annual Contribution \$ _____

Certification

I certify that I am eligible for an Aetna HSA. I certify that I do qualify to make the HSA deposit specified above. I received and will retain with me a copy of the Aetna's HSA Disclosure Statement and of the Aetna's HSA Terms and Conditions. I have read, understand and agree in its entirety with the Aetna's HSA Disclosure Statement and the Aetna's HSA Terms and Conditions. I understand that I have the right to request a copy of this Form.

Account Holder Signature _____ Date _____