



Health Savings Account Employer Group Application

Please attach this form to the initial deposit.

1. EMPLOYER INFORMATION		<i>Please print clearly. All fields are required.</i>	
NAME OF EMPLOYER			EIN - Taxpayer ID Number
MAILING ADDRESS	Address		
	City	State	Zip
CONTACT INFO	Name of Contact Person		
	Telephone Number		Email Address

2. HEALTH PLAN INFORMATION		<i>All fields are required.</i>	
NAME OF HEALTH INSURANCE COMPANY / PLAN	ANNUAL DEDUCTIBLE AND AMOUNTS	EFFECTIVE DATE	
	<input type="checkbox"/> Single Deductible \$ _____ <input type="checkbox"/> Family Deductible \$ _____	/	/

3. INITIAL SERVICE FEES
AMOUNTS DUE
PLEASE COMPLETE THE ATTACHED LIST BILL. THE LIST BILL AMOUNT MUST MATCH THE INITIAL PAYMENT TO INSURE THAT CORRECT AMOUNTS ARE CREDITED TO EMPLOYEES.
TOTAL AMOUNT IS DUE WITH THE INITIAL ENROLLMENT. PLEASE MAKE CHECKS PAYABLE TO STERLING HSA.

4. PLANNED EMPLOYER CONTRIBUTIONS

EMPLOYER'S REGULAR CONTRIBUTION AMOUNT	Single Deductible \$	Payments are planned (check one) : <input type="checkbox"/> Every Pay Period <input type="checkbox"/> Monthly <input type="checkbox"/> 1 st <input type="checkbox"/> 15 th <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually <input type="checkbox"/> Not Regularly Planned <input type="checkbox"/> I will not contribute to my employee's HSA accounts, but will allow pre-tax payroll deduction for my employee's HSA contribution.	Method of payment: <input type="checkbox"/> Check <input type="checkbox"/> Payroll <input type="checkbox"/> Direct Deposit / Electronic Funds Transfer
	Family Deductible \$		

5. BROKER AGENT INFORMATION*Please print clearly.*

BROKER NAME			
AGENCY NAME			
MAILING ADDRESS	Address		
	City	State	Zip
CONTACT INFO	Telephone Number		Email Address
	Sterling HSA Representative Name (if applicable)		

6. EMPLOYER SIGNATURE*Required*

_____	_____
Employer Signature	Date

Company Name	