STERLING ADMINISTRATION

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HEALTH SAVINGS ACCOUNT EMPLOYER GROUP APPLICATION

WE MAKE THE COMPLEX SIMPLE

Please attach this form to the initial deposit.

1. EMPLOYER INFORMATION

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

NAME OF HEALTH INSURANCE COMPANY / PLAN	ANNUAL DEDUCTIBLE AND AMOUNTS	EFFECTIVE DATE
	☐ Single Deductible $_____ ☐ 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.

4. PLANNED EMPLOYER CONTRIBUTIONS

EMPLOYER'S REGULAR CONTRIBUTION AMOUNT	Single Deductible $ Family Deductible $	Payments are planned (check one) : ☐ Every Pay Period ☐ Monthly ☐ 1st ☐ 15th ☐ Quarterly ☐ Annually ☐ Not Regularly Planned ☐ 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: ☐ Check ☐ Payroll ☐ Direct Deposit / Electronic Funds Transfer
MONTHLY MAINTENANCE	☐ Employer WILL cover Monthly Maintenance fees for employees. *Please select plan type below.* ☐ Standard ☐ Value	☐ Employer WILL NOT cover Monthly Maintenance fees for employees.	

5. BROKER AGENT INFORMATION

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

6. EMPLOYER SIGNATURE

Employer Signature Date

Company Name