



HEALTH SAVINGS ACCOUNT PARTICIPATION FORM

Please fill out this form in its entirety in order for us to properly administer your plan. If you have any questions on how to complete the form, please call our support staff at 1.866.702.9033. When complete, either fax the form to 1.701.365.6460 or mail to: HSA Department, 4501 23rd Ave S, Fargo ND 58104

I. EMPLOYER INFORMATION	
Employer's Name _____	
Employer's Street Address _____	
City _____	State _____ Zip Code _____
Employer's Tax I.D. Number _____ SIC Code _____	
Nature of Business _____	
Type of Corporation <input type="radio"/> S Corporation <input type="checkbox"/> C Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor	
<input type="checkbox"/> Political Subdivision/Church <input type="checkbox"/> LLC <input type="checkbox"/> Other _____	
Primary Contact	
Name _____	Title _____
Phone Number () _____	Fax Number () _____
Email Address _____	
Secondary Contact	
Name _____	Title _____
Phone Number () _____	Fax Number () _____
Email Address _____	
Number of Employees Eligible for Plan _____	

II. HSA REQUIREMENTS		
	YES	NO
1. The employer makes available a High Deductible Health Plan (HDHP), as defined in IRC Section 223 (c)(2).....	<input type="checkbox"/>	<input type="checkbox"/>
2. The employer agrees to comply with the Federal HSA requirements.....	<input type="checkbox"/>	<input type="checkbox"/>
ALL QUESTIONS MUST BE ANSWERED "YES" FOR THE HSA TO BE PROPERLY ESTABLISHED.		

III. HEALTH PLAN INFORMATION

HEALTH PLAN ADMINISTRATOR

Please indicate health plan carrier _____

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) PLAN YEAR

Effective Date _____ Renewal Date _____

HDHP DEDUCTIBLE AMOUNT

Indicate the deductible amounts for the health plan: Single \$ _____ Family \$ _____

IV. CONTRIBUTION INFORMATION

HSA's will be funded by: Employer Contributions Employee Contribution

If employer is contributing will it be, Matching Flat Dollar ? Describe _____

HSA contribution amounts will be forwarded to Choice Financial via:

- ACH initiated by Employer (Employer pushes funds to Choice Financial back account)
- ACH Program Available through Choice Financial.
- Check Wire Transfer

Please note that funds will not be made available to an individual's account until they are posted by Choice Financial.

PAYROLL INFORMATION

Payroll Contact

Name: _____

Phone Number () _____ Fax Number () _____

Email Address _____

The payroll contribution frequency is the same for all employees and is _____

The payroll contribution frequency differs by employee and is _____

Indicate the 1st payroll date for each frequency listed above

V. CAFETERIA PLAN INFORMATION

Will the HSA be part of a Cafeteria Plan? Yes No

Does this plan interact with a flexible spending account?

VI. SIGNATURES

It is agreed that necessary information concerning employees or employees and their dependants participating in or subsequent to the effective date of the Plan and employees whose participation is to be changed or discontinued shall be furnished to an HSA Customer Service Advisor on a timely basis.

I HAVE READ AND UNDERSTAND THE CHOICES WITHIN THIS PLAN DESIGN GUIDE. INFORMATION ON THE PLAN DESIGN GUIDE AND ANY ANCILLARY INFORMATION PROVIDED FOR THE PURPOSE OF ENROLLING IN THIS PLAN ARE, TO THE BEST OF MY KNOWLEDGE, CORRECT AND COMPLETE.

Signed _____ Date _____

Company Representative _____



We hereby certify to Choice Financial that we are currently complying with the appropriate laws, regulations and standards as set forth by the Bank Secrecy Act, USA Patriot Act, and OFAC. We further certify, that we will continue to comply with the appropriate laws, regulations and standards as set forth by the Bank Secrecy Act, USA Patriot Act, and OFAC. Should we cease to comply with the Bank Secrecy Act, USA Patriot Act and OFAC, we recognize a duty to Choice Financial based on our relationship to notify a Choice Financial representative of our intended action.

Name and Title

Business Name

Date