



417 Washington Street
Columbus, IN 47201
800-443-2980

HEALTH SAVINGS ACCOUNT EMPLOYER APPLICATION AND CONTRIBUTION FORM

Company Name: _____

Company Address: _____

Contact Name: _____

Phone Number: _____ Fax Number: _____

Contribution Year: _____

EMPLOYER CONTRIBUTION

Complete below the amount, if any, that Employer will contribute to participating employees Health Savings Account.

Frequency: Weekly Bi-Weekly Semi-monthly
 Monthly Quarterly Annually

Dollar amount or percentage for each period above:

Employee Only Contract: _____

Employee plus Spouse Contract: _____

Employee plus Child(ren) Contract: _____

Family Contract: _____

Contribution Method:

By Check
 By On-Demand-Transfer (ACH)

EMPLOYEE CONTRIBUTION

Will employees be given the option of making contributions to their Health Savings Account through payroll deductions?

Yes No

If yes, indicate payroll frequency: Weekly Bi-Weekly Semi-monthly Monthly

AGREEMENT

As a representative of the above employer, I acknowledge and declare that the employer wishes to offer its employees a Health Savings Account (HSA) in conjunction with the SIHO Insurance Services Qualified High Deductible Health Plan (QHDHP). I attest that the QHDHP is the only employer sponsored plan offered to the employees. If the employer is making contributions to the participants Health Savings Account, I agree to make such contributions only to the SIHO sponsored Health Savings Account trustee.

Authorized Signature: _____ **Date:** _____

Printed Name: _____

Initial Deposit - To make an initial deposit to open multiple Health Savings Accounts, complete the information below. Write the word "NEW" in the "Account Number" field. Mail this form, the enrollment material for each new account, and your check to **SIHO Insurance Services, 417 Washington Street, IN 47201**.

Subsequent Deposits - To make a deposit to multiple existing Health Savings Accounts, complete the information below. The account number should be obtained from the account holder. Mail this form and your check to **SIHO Insurance Services, 417 Washington Street, IN 47201**.

Enclose a check made payable to SIHO Insurance Services for the amount of the total deposit. PLEASE PRINT NEATLY OR TYPE.

	Employee Name	Social Security # (Required)	Account Number (8-digits, optional)	Initial Set-up Fee (if applicable)	Deposit Amount	
					Individual	Employer
S	Doe, John	xxx-xx-xxxx	xxxxxxxx	\$xx.xx	\$xx.xx	\$xx.xx
1						
2						
3						
4						
5						
6						
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11						
12						
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14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
Total Deposit Amount						
Check Number						
Date Deposit Mailed						