Flexible Spending Account (FSA) Employee Enrollment Form

HealthEquity®
Building Health Savings™

Mail or fax completed forms to:

Address: **HealthEquity, Attn: Reimbursement Accounts**
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020

Fax: 801.407.1792

Employer Information

Employer Name

Account Holder Information

First Name	M.I.	Last Name	
SSN	Gender ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	
E-mail Address		Home Phone ( )	
Physical Street Address	City	State	ZIP
Mailing Address (if different)	City	State	ZIP

Insurance Coverage

Coverage Effective Date	Coverage Type ☐ Single ☐ Family

Annual Elections

	Contribution Per Pay Period	Number of Pay Periods Remaining in Plan Year		Your Annual Election Amount
Health Care Flexible Spending Account	$	X	=	$
Limited Purpose Health Care Flexible Spending Account	$	X	=	$
Dependent Care Flexible Spending Account	$	X	=	$

Contribution Per Pay Period x Number of Pay Periods = Your Annual Election Amount

Banking Information for Direct Deposit

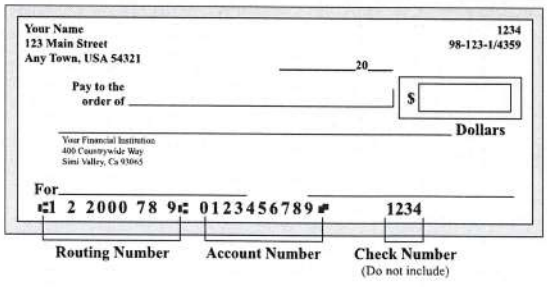
Name on Account: _____

Account type: ☐ Checking ☐ Savings

Financial institution: _____

9-digit routing number: _____

Account number: _____



Form must be accompanied by an actual or a copy of a voided check. (Deposit slips are not sufficient).

Note: This section is not required, however payments issued via EFT are not subject to the $2 check fee. By choosing direct deposit, no confirmation will be mailed to you. To verify when your last claim was processed, please call Member Services at 877.472.8632. Please contact your bank or credit union to verify receipt of payment in your account. Direct deposit may take up to 2-3 business days to take effect.

Signature

☐ I decline to participate in the FSA plan.

Print Name	Signature	Date