Health Savings Account (HSA) Enrollment Form

Revised 03/2024

WEST VIRGINIA Higher Education Policy Commission | WEST VIRGINIA Community & Technical College System | HealthEquity®

Reason for completing form:

☐ New Enrollment ☐ Changing contribution amount ☐ Change in family status ☐ Cancellation

Employer Information

Enrollment cannot be processed without your employer's name.

Employer name:

Account Holder Information

First name:	M.I.:	Last name:	
SSN:	Gender: ☐ Male ☐ Female	Date of birth (mm/dd/yyyy):	
Email address:		Preferred phone:	
Physical street address:	City:	State:	ZIP:
Mailing address (if different):	City:	State:	ZIP:

Health Insurance Coverage

Insurance carrier: **West Virginia Public Employees Insurance Agency (PEIA) PPB Plan C**

Coverage type:

☐ Single ☐ Family

Authorization and Certification

By opening a health savings account (HSA) with HealthEquity, you accept the terms of HSA enrollment and the custodial agreement. You may view the HSA custodial agreement. Upon enrollment, you understand and agree to the following:

- You are covered by a qualified high deductible health plan (HDHP).
- **You are not covered by any other non-qualified health coverage, including Medicare Part A and Part B.**
- You are not claimed as a dependent on another individual's tax return.
- HealthEquity must verify your identity in order to open your HSA.

For further information regarding HSA laws, go to https://www.irs.gov/pub/irs-pdf/p969.pdf

Print name: X	Signature: X	Date: X

Contribution Information and Authorization

Frequency of payroll: **Bi-Weekly**

Please withhold $_____ from every pay **Date to begin deduction:** ☐ Immediately or ☐ Date: Do you wish to participate in the Age 55 catch-up? ☐ **Yes** ☐ **No**

Signature: X	Date: X

2024 annual HSA contributions

Coverage type	Total annual contribution
Self-Only	$4,150
Family	$8,300

2024 HSA age 55 catch-up

Coverage type	Total annual contribution
Self-Only	$1,000
Family	$1,000

Your HSA cash balance is held at an FDIC-insured or NCUA-insured institution and is eligible for federal deposit insurance, subject to applicable requirements and limitations.

Return this form to your campus Benefit Coordinator

Human Resources Use Only:

Signature: Date:

Effective Date of First Deduction: