

# HEALTH SAVINGS ACCOUNT (HSA) SELF ENROLLMENT REQUEST

Voya Benefits Company, LLC  
A member of the Voya® family of companies  
Health Account Solutions: PO Box 1168, Minneapolis, MN 55440  
Phone: 833-232-4673; Fax: 855-370-0670; Email: HASInfo@voya.com



Health Account Solutions, including Health Savings Accounts, Flexible Spending Accounts, Commuter Benefits, Health Reimbursement Arrangements, and COBRA Administration offered by Voya Benefits Company, LLC (in New York, doing business as Voya BC, LLC). HSA custodial services provided by Voya Institutional Trust Company.

**Note:** All fields with an \* are required.

Name\* (First) \_\_\_\_\_ (Last) \_\_\_\_\_  
Residential Address\* (Cannot be P.O. Box) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Mailing Address\* (Can be P.O. Box) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Home Telephone Number\* \_\_\_\_\_ Work Telephone Number\* \_\_\_\_\_  
Mobile Telephone Number\* \_\_\_\_\_ Email\* \_\_\_\_\_  
Social Security Number (SSN)\* \_\_\_\_\_ Date of Birth\* \_\_\_\_\_

## EMPLOYMENT DETAILS

Employer Name\* \_\_\_\_\_ Employee Number\* \_\_\_\_\_  
Hire Date\* \_\_\_\_\_ Payroll Frequency\* (Weekly, Bi-Weekly, Monthly, Other) \_\_\_\_\_

For verification purposes, please provide your manager or supervisor's contact information using the fields below:

Employee's Manager/Supervisor Name\* \_\_\_\_\_  
Employee's Manager/Supervisor Email\* \_\_\_\_\_ Manager/Supervisor Phone Number\* \_\_\_\_\_

## MEDICAL PLAN INFORMATION FOR THE HSA-QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

HDHP Effective Date\* \_\_\_\_\_ HDHP Coverage Level (Select one):\*  Self Only  Family/Other

**HSA EFFECTIVE DATE AND CONTRIBUTION ELECTION** (Indicate your HSA effective date. The chart below can help you determine your appropriate effective date.)

If HDHP Effective Date Is:	And HSA Application Signature Date Is:	The HSA Effective Date Can Be:
First of month Example: January 1	On or prior to HDHP effective date Example: December 15	HDHP effective date or any later date Example: January 1 or later date
First of month Example: January 1	After HDHP effective date Example: January 2	Date of application or any later date Example: January 2 or later date
Other than first of month Example: January 15	On or before 1st of month following HDHP effective date Example: January 25	1st of month following HDHP effective date or later Example: February 1 or later date
Other than first of month	After the 1st of month following HDHP effective date	Date of application or any later date

HSA Effective Date (mm/dd/yyyy) \_\_\_\_\_

## DEBIT CARD

You will automatically receive a debit card, mailed to your home address, that you can use to access HSA funds when paying at the point of service/sale or when paying a bill.

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## SIGNATURE AND ACKNOWLEDGEMENTS

By executing this form:

I acknowledge that I understand I will receive an HSA confirmation email from Voya with account login instructions and I am then responsible for logging in to my account at [myhealthaccountsolutions.voya.com](http://myhealthaccountsolutions.voya.com) and accepting Terms and Conditions. I understand that until I do so, I will not have any access to contributions made to my HSA from any source.

I acknowledge that I will read the HSA Disclosure Statement and HSA Custodial Agreement (including Privacy Policy) online at [myhealthaccountsolutions.voya.com](http://myhealthaccountsolutions.voya.com) and agree to receive future notices of updates by visiting [myhealthaccountsolutions.voya.com](http://myhealthaccountsolutions.voya.com), and to review the Custodial Agreement (and Privacy Policy) no less frequently than annually.

I understand that by opening an HSA I am consenting to receive electronic documents, including the monthly HSA Account Statement, and that if I want to opt out of electronic documents I can do so by requesting the change through the Statements & Notifications area of my secure account at [myhealthaccountsolutions.voya.com](http://myhealthaccountsolutions.voya.com). A fee may apply for each paper HSA Account Statement sent.

 Employee Signature\* *(Required.)* \_\_\_\_\_ Date \_\_\_\_\_