STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS

Health Savings Account

Enrollment and Payroll Deduction Election/Change Form

I would like to open my health savings account as follows:

Account Holder Information

First Name	M.I.	Last Name	
SSN	Gender ☐ Male ☐ Female	Date of Birth(mm/dd/yyyy)	
Email Address		Home Phone ( )	
Physical Street Address	City	State	ZIP
Mailing Address (if different)	City	State	ZIP
Agency Name	Agency Number	Monthly Deduction	

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 here: http://healthequity.com/en/Site/EducationCenter/Forms.aspx by looking under Health Account Forms and Agreements. Upon enrollment, you understand, acknowledge 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 and Tri-care.
- You do not have access to dollars in a flexible spending account (FSA) to pay for any medical expenses before the required High Deductible Health Plan deductible is met, including a spouse's FSA.
- You are not claimed as a dependent on another individual's tax return.
- Health Equity must verify your identity in order to open your HSA.
- I authorize the pre-tax reduction of my salary on a monthly basis by the amount designated below. I understand that I may change my HSA salary reduction election once a month. If an election change is entered into eEnrollment between the first and fourteenth days of the month, the effective date will be the first of the next month. If the change is entered on or after the fifteenth of the month the effective date will be the first of the second month following the entry.
- I understand that any withdrawals/distributions made from my HSA for health care expenses incurred prior to the establishment of my HSA or for other non-qualified types of expenses will be **taxable** and may be subject to additional penalties in accordance with IRS regulations. I further understand that it is solely my responsibility to report these withdrawals/distributions to the IRS and that I am solely responsible for any resulting taxes and penalties.

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

Print Name	Signature	Date