RESET FORM

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.

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 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 and agree to receive future notices of updates by visiting 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. A fee may apply for each paper HSA Account Statement sent.

Employee Signature* *(Required.)* _____ Date _____