RESET FORM

HSA ESTABLISHMENT APPLICATION

Voya Benefits Company, LLC
A member of the Voya® family of companies
Customer Service: PO Box 929, Manchester, NH 03105
Phone: 833-232-4673; Fax: 855-370-0670; Email: voyasupport@voya.benstrat.com

Health Savings and Spending Accounts, 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). Administration services provided by WEX Health, Inc. and Benefit Strategies, LLC.

SECTION 1. ACCOUNTHOLDER INFORMATION *(All fields are required.)*

Note: As a part of the U.S. Patriot Act of 2001, financial institutions must verify the identity of any person seeking to open an account. If the information provided in Section 1 cannot be verified via the ID verification process, we will contact you to obtain documentation to validate the accuracy of the information. HSA funds will be on hold until the ID verification hold has been cleared. If not cleared within 60 days of notice, your HSA will be closed and any funds returned to the originating account.

Print clearly to ensure your account is set up accurately.

Employee Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Birth Date *(mm/dd/yyyy)* _____ Social Security Number (SSN) _____ Gender: ☐ Male ☐ Female

Daytime Phone (_____)_____ Email [1] *(Required to receive important account notifications.)* _____

Address *(Cannot be PO Box.)* _____

City _____ State _____ ZIP _____

Hire Date _____ Division *(if applicable)* _____

SECTION 2. MEDICAL PLAN INFORMATION FOR THE HSA-QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

HDHP Effective Date *(mm/dd/yyyy)* _____ HDHP Coverage Level *(Select one.)*: ☐ Self Only ☐ Family/Other

SECTION 3. HSA EFFECTIVE DATE *(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)* _____

SECTION 4. DEBIT CARD

You will automatically receive a set of two identical debit cards that you can use to access HSA funds when paying at the point of service/sale or when paying a bill. Debit cards will be mailed to your home address.

Additional and replacement cards can be ordered via your consumer portal, or by contacting Voya at 833-232-4673 or voyasupport@voya.benstrat.com. Fee may apply.

[1] *Your email address will not be shared, sold or used for purposes other than contacting you regarding your HSA.*

SECTION 5. DISTRIBUTION REQUEST

Indicate below how you would like to receive funds when you request a distribution. You can request a distribution of funds through your online account at www.voya.com/myhealthaccounts, the Voya mobile app, Voya Health Accounts, or submitting the HSA Distribution form. The form can be downloaded from www.voya.benstrat.com or you can contact Voya to have the form sent to you.

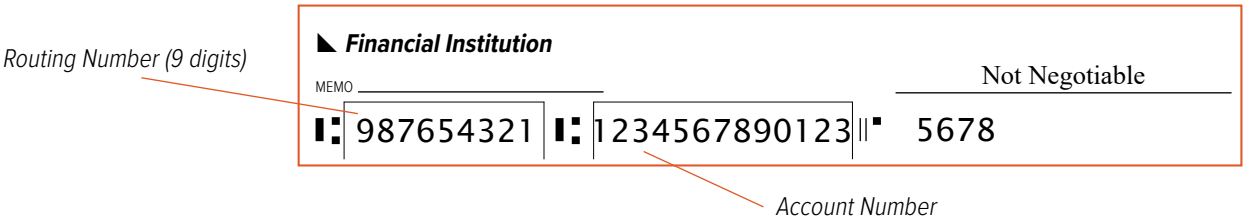
Select one.: ☐ Direct Deposit – No fee. Complete below. ☐ Check – No fee.

Direct Deposit Information

Bank Name _____ Bank Account Type: ☐ Checking ☐ Savings

Bank Routing Number *(9 digits)* _____ Bank Account Number _____

Sample Check



SECTION 6. BENEFICIARY DESIGNATION *(Share percentages must equal 100% for primary and 100% for contingent.)*

I designate the following individual(s) or entity as my primary or contingent death beneficiary(ies) of this HSA.

If I am married in common law or in a community or marital property state, I must designate my spouse as Primary Beneficiary unless my spouse's signature is obtained and notarized below.

	Name *(First, MI, Last)*	Birth Date	Gender	SSN	Relationship	%	Is this Beneficiary Primary or Contingent?
1			☐ M ☐ F				☐ Primary ☐ Contingent
	Address			Phone ( )			
2			☐ M ☐ F				☐ Primary ☐ Contingent
	Address			Phone ( )			
3			☐ M ☐ F				☐ Primary ☐ Contingent
	Address			Phone ( )			

Select one.:

☐ I am not married. If I become married at a future date, I understand I must complete a new Beneficiary Designation form.

☐ I am married. I understand that if I choose to designate a primary beneficiary other than my spouse, he or she must agree to the designation by signing below. **My spouse's signature must be notarized.**

Spouse Signature _____ Date _____
(Only required if spouse is waiving beneficiary rights.)

Subscribed and sworn to before me this _____ day of _____, 20 _____ .

My commission expires _____ Notary Public _____

SECTION 7. 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 www.voya.benstrat.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 www.voya.benstrat.com and agree to receive future notices of updates by visiting www.voya.benstrat.com, and to review the Custodial Agreement (and Privacy Policy) no less frequently than annually. (Privacy Policy can also be viewed by visiting www.healthcarebank.com.)
- 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 www.voya.benstrat.com. A fee may apply for each paper HSA Account Statement sent.


Employee Signature _____ Date _____