HealthEquity
Building Health Savings

CALIFORNIA'S VALUED TRUST
Healthcare Benefits for the Education Community

Health Savings Account (HSA) Employee Enrollment Form

District Information: (Enrollment cannot be processed without your employer's name)		
District Name		
Account Holder Information:		
First Name	M.I.	Last Name
SSN	Date of Birth (mm/dd/yyyy)	

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 and agree to the following:

1. You are covered by a qualified high deductible health plan (HDHP).
2. You are not covered by any other non-qualified health coverage, including Medicare.
3. You do not have access to dollars in a flexible spending account (FSA) to pay for any medical expenses before the required HDHP deductible is met, including a spouse's FSA.
4. You are not claimed as a dependent on another individual's tax return.
5. HealthEquity must verify your identity in order to open your HSA.
6. You must authorize CVT to disclose enrollment and health information to HealthEquity.

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

By electing to open an HSA, you confirm the following:

1. I meet the HSA eligibility requirements as listed above.
2. I wish to establish an HSA with HealthEquity.
3. I understand that I may be subject to tax penalties if I do not use my HSA in accordance with the IRS regulations. Visit http://www.irs.gov/pub/irs-pdf/p969.pdf to review the regulations.
4. I accept the terms of the HealthEquity HSA Custodial Agreement. Visit http://healthequity.com/en/Site/EducationCenter/Forms.aspx to view the agreement.
5. I understand that in compliance with the USA Patriot Act, HealthEquity must verify the identity of all individuals who seek to open an HSA. I understand that as part of this identity verification process, I may be asked to provide additional information and/or documentation before my account can be established.

Print Name	Signature	Date

Additional signature required on second page.

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Authorization to CVT for use and disclosure of enrollment and health information:		
I authorize CVT to share my enrollment and health information with HealthEquity for the purpose of administering and coordinating payments under my HSA. I understand that I may revoke this authorization at any time, and that it will remain valid until revoked in writing by me. I also understand that CVT will not condition any treatment, payment or eligibility upon me providing this authorization and that my enrollment or health information may be re-disclosed by Health Equity as necessary to administer my benefits.		
Print Name	Signature	Date