

Health Savings Account Contribution & Design Change Form



HSA Owner Information:

Employer Name _____

Employee Name _____ Social Security Number _____

Address _____

City _____ State _____ Zip _____

Phone (____) _____ Email _____

1. Current Account Design:

(Please select one)

Spender Saver

New Account Design:

(Please select one)

Spender Saver

2. Current Per Pay Contribution (employee amount only) \$ _____

New Per Pay Contribution (employee amount only) \$ _____

Date of change request ____/ ____/ _____

I hereby authorize Alliance Benefit Group to modify the design of my Health Savings Account as directed above. I understand that my employer will pay the monthly administration fees while I am an active employee if I have a Health Savings Account and I am currently enrolled in my employer's High Deductible Health Plan. If my situation is different from the previous statement, I understand that changing the account design may alter any applicable fees. If I made a change to my Health Savings Account contribution, I authorize my employer to deduct from my pay the amount elected above.

Signature of HSA Owner

Date

Please Return This Form to Your Human Resources Department

Human Resources Department Use Only

HSA Contribution Change Entered by: _____ Date Entered in System: _____

Mail Original Form to Alliance Benefit Group, Attn: HSA Department, PO Box 1226, Albert Lea, MN 56007 or fax completed form to 866-808-7823