



Health Savings Account (HSA) Enrollment Form for Employees

Please mail completed form to:
Wells Fargo Health Benefit Services, 381 East Broadway #110, Salt Lake City, UT 84111

Contact Information				
Last Name	First Name	M.I	Date of Birth	Social Security #
Street Address		City		State Zip
E-Mail Address			Home Phone # (area code)	Work Phone # (with area code & ext.)
Name of Employer				Employer EIN
Health Insurance Provider		Coverage Effective Date		My HSA Contribution Limit
HDHP Deductible		Coverage for <input type="checkbox"/> Individual <input type="checkbox"/> Family (includes Employee + 1, Employee + Spouse, and Employee + Children, Family)		
Account Setup		Investment Elections		
<input type="checkbox"/> Please open a Health Savings Account (HSA) in my name. I certify that I am eligible to contribute to an HSA according to federal regulations and tax code §223, and my annual contribution will not exceed the amount permitted for my situation. Note: If you elect to have scheduled pre-tax payroll deductions, these must be established through your employer. Any future changes must also be done through your employer. Please contact your employer for details.		WF Cash Investment Money Market - Service _____ % Wells Fargo Strategic Income I _____ % Wells Fargo Moderate Balanced I _____ % Wells Fargo Growth Balanced I _____ % Wells Fargo Strategic Growth Allocation I _____ % Wells Fargo Diversified Equity I _____ % Note: The first \$100 you contribute will be directed to the un-invested cash fund. Thereafter, your contributions will be invested according to your investment elections. If you do not make investment elections, your funds will be invested in the Cash Investment Money Market. Future changes to your elections can be made online or by calling your HSA customer service number.		
<p>I hereby request that <i>Wells Fargo Health Benefit Services</i> establish a Health Savings Account (HSA) in my name. I acknowledge that this account will be established according to the <i>Health Savings Account Disclosure and Custodial Account Agreement</i>. I certify that <i>Wells Fargo Health Benefit Services</i> is authorized to act in accordance with any future documents bearing my signature. I understand that I may revoke this agreement at any time by submitting a completed <i>Health Savings Account (HSA) Closure Form</i> to <i>Wells Fargo Health Benefit Services</i> and account assets will be returned to me according to HSA Federal Regulations.</p> <p>I also understand that Federal law requires all financial institutions to obtain and verify personal information that will identify those individuals who open a new account. I hereby acknowledge that the information contained in this document will be used to verify that I am not associated with the funding of terrorist groups or other money laundering activities.</p> <p>I acknowledge that I have received, at my request, and reviewed the fund prospectus for the fund selected and have determined that such fund is an appropriate investment vehicle for the account. I understand from reading the prospectus for the Wells Fargo Funds that Wells Fargo Funds Management, LLC serves as investment advisor and Wells Fargo Bank, N.A., serves as custodian. I also understand that Wells Fargo Bank, N.A. will be paid, and certain of its affiliates may be paid, fees for services to the Wells Fargo Funds and that those fees are described in the prospectus.</p> <p>I understand that investments in any such fund are not obligations of, or endorsed or guaranteed by, Wells Fargo Bank or its affiliates and are not insured by the Federal Deposit Insurance Corporation. I acknowledge that I have full power to direct investments of the accounts. I understand that I may change this direction at any time and that it shall continue in effect until revoked or modified by me.</p>				
Primary Beneficiary Information				
Name		Relationship	Social Security #	
Address		City	State	Zip
<p>The rights of the beneficiary named above shall be subject to all terms and conditions of the Health Savings Account Disclosure and Custodial Account Agreement (the "Plan Document") and shall be effective only if received by Wells Fargo Health Benefit Services prior to the death of the account holder. This designation applies to all of the HSA funds that remain undistributed from this account at the account holder's death. If the account holder wishes to name additional primary beneficiaries or contingent beneficiaries, he or she may obtain a form by calling his or her HSA customer service number. If no primary beneficiary survives the account holder, payment of funds shall be made to surviving contingent beneficiaries or if none, in accordance with the terms of the Plan Document. This designation may be changed at any time by filing a written change with Wells Fargo Health Benefit Services.</p>				
Signature of Account Holder			Date of Application	

Website: <http://www.wfhbs.com/kaiserpermanente>

Phone: (866) 890-8308

Fax: (888) 824-3868