Clarity | BENEFIT SOLUTIONS™

HEALTH SAVINGS ACCOUNT ENROLLMENT FORM

PLEASE COMPLETE THIS FORM AND SUBMIT TO YOUR EMPLOYER

Last Name _____ **First Name** _____

Social Security Number _____ **Date of Hire** _____

Date of Birth _____

Address _____ **City** _____

State_____ **Zip** _____ **Phone** (____) _____

☐ **(Check Here if Mobile Number)**

E-mail Address

_____

Option I: Health Savings Account

Enter an **ANNUAL** PRE-TAX contribution election.

Single $_____ **All Others $**_____

Option II: Limited Purpose FSA *(Dental & Vision **ONLY**)*

Enter an **ANNUAL** PRE-TAX contribution election up to maximum*: **$**_____

Option III: Waiver of Tax Benefits

☐ I have been given the opportunity to enroll in these tax-savings plans and have declined to participate. I understand that I will lose all tax savings that I may have received as a participant.

Employee Signature _____ Date_____

For Employer Use Only

Effective Date: _____

**Annual plan limits are available at claritybenefitsolutions.com/resources/plan-limits.*