866-451-3399

Health Savings Account (HSA) Data Collection Worksheet

Please complete and submit this worksheet to your employer. This is an internal document used by your employer for data collection purposes. Worksheets returned to WEX Health, Inc. cannot be processed.

*=Required Fields

Step 1: Account Holder Information

*Employer Name (Do not abbreviate)

Employee ID Number

*Account Holder Name (First, MI, Last)

*Social Security Number

*Physical Address (Cannot be PO Box)

*City

*State

*Zip

*Email Address

*Day Telephone

*Date of Birth (mm/dd/yyyy)

*Hire Date (mm/dd/yyyy)

Step 2: HSA Election for Current Tax Year

Employee Contribution

Note: I understand my Health Savings Account (HSA) will be set up effective the first day of the month following the date this worksheet is signed.

*Per Pay Period Amount: (to be deducted each pay period) $

Employer Contribution: Check with your employer to determine if you will receive employer contributions. Both employee and employer contributions will be applied to your annual IRS maximum.

HDHP Coverage Level
(*check one)

☐ Single / ☐ Family

*HDHP Coverage Date: (mm/dd/yyyy)

Note: There may be tax consequences if HSA contributions exceed the IRS governed limit. To determine the maximum HSA contribution for the current tax year visit www.wexinc.com.

Step 3: Authorized Signature

By signing this application I represent that: 1) I am covered under a high deductible health plan (HDHP); 2) I am not covered by any other health plan that is not an HDHP; 3) I am not enrolled in Medicare; 4) I cannot be claimed as a dependent on another person's tax return; and 5) I will read and agree to the HSA Custodial Agreement and Disclosure Statement on the WEX Health, Inc. Participant Portal. I understand that if my spouse is enrolled in a general-purpose FSA (a non-HDHP), I am not eligible to contribute to an HSA. I understand my Health Savings Account will be set up effective the first day of the month following the date the Enrollment Application is signed. Further, I understand that my Health Savings Account cannot be effective prior to my HDHP coverage date.

*Signature of Account Holder

*Date