HSA Health Insurance Company
PO Box 709718
Sandy, UT 84070-9718
www.hsahealthplan.com

HSA Health Plan: Group Application

Group Name_____

Effective Date: _____ Length of contract _____months

Street Address _____

City_____ State:_____Zip:_____

Employer Tax ID#_____

Company Type (LLC, C Corp, S Corp, etc.) _____

List all DBAs or other names used: _____

# of employees: _____ # of enrollees waiving due to other group coverage: _____

# of eligible employees: _____ # of enrollees waiving without other group coverage: _____

# of ineligible employees: _____ # of enrollees currently in a new hire waiting period:_____

# of employees outside of UT:_____ # of enrollees on COBRA: _____

# of enrollees are retired: _____

Health Savings Account

Are you currently a full replace HSA Group?_____Yes_____No

If so, are your employees HSA's currently administered by HealthEquity?____Yes ____No

Group Contact Information

Contact 1
Name: _____ Title: _____

Phone Number: _____ Email: _____

Contact 2
Name: _____ Title: _____

Phone Number: _____ Email: _____

Product Selection

Product 1	**Product 2**
Deductible Individual _____	Deductible Individual_____
Deductible Family _____	Deductible Family _____
Deductible embedded? **Yes/ No**	Deductible embedded? **Yes/ No**
Individual Maximum Out of Pocket _____	Individual Maximum Out of Pocket _____
Family Maximum Out Of Pocket _____	Family Maximum Out Of Pocket _____
Maximum Out Of Pocket embedded? Yes/ No	Maximum Out Of Pocket embedded? Yes/ No
Coinsurance_____	Coinsurance_____
Copayments_____	Copayments_____
Rx cost sharing_____	Rx cost sharing_____
Monthly Premiums for this product:	Monthly Premiums for this product:
Single $_____	Single $_____
Employee + Spouse $_____	Employee + Spouse $_____
Employee + Child $_____	Employee + Child $_____
Employee + Children $_____	Employee + Children $_____
Family $_____	Family $_____

Other plan/product details including any alternative funding details:

_____

_____

_____

_____

Employer HSA Contributions: Please explain any employer HSA contributions:

_____

_____

Eligible Employees

To be eligible, employees must work at least _____hours per week.

Domestic Partners **are/ are not** covered.

Newly Eligible Employees
The Employer Waiting Period is _____ days and the effective date is on _____. If multiple classes, please explain:

_____
(Note that waiting period cannot be such that it can exceed 90 days)

Employer Monthly Contribution
Employer must contribute an amount equivalent to at least_____% of the single coverage Premium and/or_____% of all rating tiers.

Dependent Age Limitations
Dependent children are eligible for coverage up to age 26, unless they meet the criteria for disabled children as specified in the Certificate of Coverage.

Termination of Coverage
Employee and Dependent(s) coverage will terminate as of the end of the month in which termination of eligibility occurs.

Leave of Absence
Eligible employees are granted a leave of absence by the Employer for up to 60 days. Leave time can only be accrued and used by the employee using the leave time. Leave Banks, where employees share or purchase leave time from other employees, are not allowed.

If minimum employee participation and Employer contribution requirements are satisfied, the Master Group Policy and its terms shall commence on the effective date for a term of 12 months.

In addition to any other applicable Premium, Insured Employees shall pay the cost sharing amounts as described in the Outline of Coverage. "Not Covered" on the Outline of Coverage indicates that the service is not covered regardless of any other statement of coverage.

Coverage is made on the basis of information provided to HSA Health Insurance Company by the Employer and its employees and is subject to the above criteria as well as properly completed employee applications. Employer understands that is relied upon in making decisions about coverage and payment. Employee applications must be submitted to and approved by HSA Health Insurance Company before the proposed effective date.

This Group Application, as part of the Master Group Policy, must be signed by Employer and received by HSA Health Insurance Company before the Contract can be finalized.

Employer understands and agrees that any coverage provided will be limited according to the terms of this Group Application, and the Master Group Policy including the Outline(s) of Coverage.

This Group Application is attached to and made a part of the Master Group Policy. It cancels and replaces all other applications, if any, attached to the Master Group Policy. This Application will be void if not signed and returned to the Company prior to the effective date.

Company Name: _____

Company representative: _____

Signature:_____Date: _____