

HSA Eligibility Form

Plan Name: _____

Enrollee Name: _____ ID/SSN #: _____

Medicare/Social Security/Tax

Are you currently collecting social security benefits? Yes No

Are you currently enrolled in Medicare? Yes No I'm not sure

Have you ever received an ID card from Medicare? Yes No

Can you be claimed as a dependent on another persons tax return? Yes No

Are you covered by a general purpose health care flexible spending account (FSA) or health reimbursement account (HRA)? Yes No

Other Healthcare Coverage

Do you receive benefits under Tricare (Tricare is a health care program of the Department of Defense Military Health System)? Yes No

Have you received medical benefits from Veterans Administration (VA) for any non-service-connected disabilities at any time during the previous three months?
 Yes No

Are you or any family members currently enrolled in any other healthcare coverage or plan (including flex plans which allow medical reimbursements)?
 Yes (please complete this section) No (skip the rest of this section)

Please list all family members enrolled in the other coverage:

Does the other coverage qualify as an HSA eligible High Deductible Health Plan?
 Yes No I'm not sure

I hereby certify that the above answers are true and complete to the best of my knowledge and are the basis under which benefits are provided under this Plan.
I agree to notify the Plan in the event of a change in any of the information requested above.

Signature of Enrollee

Date