AMERICAN BENEFITS GROUP

HSA ENROLLMENT FORM

First Name: _____ Last Name: _____

Date of Birth:_____SSN: _____

Street Address: _____

City:_____State:_____Zip Code: _____

Email:_____Phone: _____

Employer: _____ Division: _____

See the current IRS Annual HSA Contribution Limits here:
https://www.amben.com/participants/annual-irs-benefit-limits/

Catch-up Contribution (55 or Older): $1,000

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Per Pay Period Contribution: _____

I hereby authorize my employer to reduce my salary (on a pre-tax basis) by the amount necessary to pay for the coverages indicated above.

Employee Signature: _____ Date:_____

Submit this form to your HR Department

If you have any questions on how to complete this form,
call American Benefits Group at 800-499-3539 or email support@amben.com

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EMPLOYER PLEASE COMPLETE:

Effective Date: _____ ☐ Individual ☐ Family

Employer Signature: _____ Date:_____

Fax: 877-723-0147 or email: processing@amben.com

American Benefits Group | PO Box 1209, Northampton, MA 01061-1209 | 800-499-3539