

HR Concepts, LLC

"Your Third Party Administrator of Choice"

Health Savings Account Employer Application (HSA)

Part I. Employer Information

Employer Name: _____

Mailing Address: _____ City: _____ St.: _____ Zip: _____

Street Address (if different): _____ City: _____ St.: _____ Zip: _____

Telephone: _____ Fax: _____ Tax Id #: _____

Primary Point of Contact: _____ Phone Ext: _____ Email: _____

Secondary Point of Contact: _____ Phone Ext: _____ Email: _____

Part II. Plan Design

Original Effective Date of Section HSA Plan: _____ Plan Year: _____ to _____

Short Plan Year: Yes / No If yes, indicate plan year: _____ to _____

Does the Employer offer a qualified HSA Health plan? Yes _____ No _____

What is the annual deductible on the HDHP: Single \$ _____ 2 Person \$ _____ Family \$ _____

What is the annual Employer Funding of HSA: Single \$ _____ 2 Person \$ _____ Family \$ _____

Will Employer allow for Employee contributions through payroll deductions: Yes _____ No _____

When will Employer submit the HSA funds for deposit?
Weekly _____ Monthly _____ Quarterly _____ Annually _____

Is Employer going to submit funds through HRC or direct to Bank: HRC _____ Bank _____



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Phone: (603) 647-1147 • Fax: (603) 647-2329 • email: info@HRConcepts.biz
www.HRConcepts.biz • 9 Cedarwood Drive, Unit 8 • Bedford, NH 03110

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Part III. Eligibility

Hours: _____ Length of Service: _____
How Many Employees are Eligible: _____ Total Number of Employees: _____

Part IV. Tax Filing Information

Plan Name: _____
Is this a new plan? Yes / No If No, What is the reinstatement Date: _____
Business Structure (Ex: S Corp, C Corp, LLC): _____ St. Organized: _____
Is this a Controlled Group: Yes / No **(If yes, fill in below)**
Employer 1 Name: _____ Number of Employees: _____
Address: _____ City: _____ St.: _____ Zip: _____
Tax Id#: _____ Business Structure: _____ St. Organized: _____

Part V. Signatures and Fees

Broker: _____ **Pay: Setup / Renewal / Admin**

Setup/Installation Fee: \$ _____ Account Fee: \$ _____ (Minimum Billing/ Employee / Month)
Bank Fee: \$ _____ (Per Account)
Annual Renewal Fee: \$ _____ Account Fee: \$ _____ (Minimum Billing/ Employee/Month)

Authorized Signature of ER: _____ Title: _____ Date: _____



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