

Group Health Savings Account (HSA) & Sponsorship Application



providentcu.org

(800) 632-4600 • FAX (650) 595-2409

Business Name: _____

Street Address: _____

City/State/Zip: _____

Web Site: _____

Contact Name: _____ Phone: _____

Is this your company headquarters? Yes No # of employees at this location: _____

Additional office locations: _____

Additional office locations: _____

Additional office locations: _____

Acceptance by Provident Credit Union By: _____ Title: _____ Department of Financial Institutions Date: _____ Approved: <input type="checkbox"/> Yes <input type="checkbox"/> No By: _____
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Number of employees: _____

Number of employees: _____

Number of employees: _____

In addition to HSA services and information, please provide the following:

- Onsite visits/presentations to promote Provident Credit Union membership, products, and services
- Payroll stuffers
- Breakroom posters
- Intranet listing
- New hire packet inserts

Health Plan Information

Name of Health Insurance Company/Plan: _____

Annual Deductible—Single \$ _____ Annual Deductible—Family \$ _____ Effective Date: _____

Planned Employer Contributions

Payments are Planned (check one): Every Pay Period Monthly Quarterly Annually Not regularly planned
 I will not contribute to my employee's HSA. I will allow pre-tax payroll deduction for my employee's HSA contribution.

Employer Contribution Amount: Single \$ _____ Family \$ _____ Method of Payment: Check Payroll Direct Deposit/ACH*

* For Direct Deposit/ACH, attach a voided check. Initial payment must be made by check payable to Provident Credit Union.

Broker Information

Broker/Agency Name: _____

Street Address: _____

City/State/Zip: _____

Representative: _____

Telephone: _____ Email: _____

Signature

By (print name): _____ Signature: X

Title: _____ Date: _____



This credit union is federally insured by the National Credit Union Administration.

Group Health Savings Account (HSA) List Bill



providentcu.org

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Business Name: _____

Contact Person: _____

Contact Telephone: _____ Email: _____

Date(s) of Contribution: _____

(Total amount is due with the initial enrollment and must be made by check payable to Provident Credit Union.)

Monthly fee* per employee to be paid by: Employer Employee

* See service charge schedule.

	Employee Name	Employee Contribution	Employer Contribution	Total
1		\$	\$	\$
2		\$	\$	\$
3		\$	\$	\$
4		\$	\$	\$
5		\$	\$	\$
6		\$	\$	\$
7		\$	\$	\$
8		\$	\$	\$
9		\$	\$	\$
10		\$	\$	\$
11		\$	\$	\$
12		\$	\$	\$
13		\$	\$	\$
14		\$	\$	\$
15		\$	\$	\$
16		\$	\$	\$
17		\$	\$	\$
18		\$	\$	\$
19		\$	\$	\$
20		\$	\$	\$
21		\$	\$	\$
22		\$	\$	\$
23		\$	\$	\$
24		\$	\$	\$
25		\$	\$	\$
	Total			\$