Group Health Savings Account (HSA) & Sponsorship Application

PROVIDENT CREDIT UNION
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: _____ Number of employees: _____

Additional office locations: _____ Number of employees: _____

Additional office locations: _____ Number of employees: _____

Acceptance by Provident Credit Union

By: _____

Title: _____

Department of Financial Institutions

Date: _____ Approved: ☐ Yes ☐ No

By: _____

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: _____

Your savings federally insured to at least $250,000 and backed by the full faith and credit of the United States Government
NCUA
National Credit Union Administration, a U.S. Government Agency

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

Group Health Savings Account (HSA) List Bill

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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			**$**