



# Aetna HealthFund® Health Savings Account (HSA) Enrollment (Small Group)

## Instructions

- Please print clearly, with black ink. If you make an error, strike through it, and write your initials next to the correction.
- Please do not submit check contributions with this form.
- Mail completed form to: **Attn: HSA Enrollment, Aetna, 151 Farmington Avenue, Hartford, CT 06156-8961**

## Account Holder Information

Name : Last		First		MI
Birthdate (MM/DD/YYYY) / /	Social Security Number / /	Daytime Telephone Number ( ) -	Evening Telephone Number ( ) -	
Street Address _____ _____				
City		State	Zip Code	Country
E-mail Address (Optional)	High Deductible Health Plan Effective Date (MM/DD/YYYY) / /	Type of Coverage <input type="checkbox"/> Individual <input type="checkbox"/> Family		
Employer		Control-Suffix-Account Number (employer use only) <b>619901 / 11 / 001</b>		

## Additional Aetna HSA Visa® Debit Card Option

I would like an additional Aetna HSA Visa® debit card for my spouse or dependent listed below at no charge. I understand that the second cardholder will have full access to all the funds in my HSA and to balance information and transaction history related to my HSA.

Second Card Holder Name:

\_\_\_\_\_  
Last First MI

## HSA Checkbook Option

I would like to order HSA checks to pay for qualified expenses (checkbook fees may apply). Please send me a Check Signature Card Form to complete.

## Statement Option

I understand that this HSA service is designed to provide me with account balance and transaction history electronically by phone or over the internet. I also understand that if I would like to receive a paper statement each month sent through the U.S. Postal Service, I can contact Member Services once I receive my Welcome Package to request this optional service.

## Certification

I certify that I am eligible to establish an HSA and that the information I have provided in this Enrollment form, including my social security number, is true and correct. Subject to acceptance of this application by Aetna Life Insurance Company ("Aetna"), I appoint Aetna as my HSA custodian. I have received, read and agree to the terms and conditions of the Aetna HSA Custodial Agreement and other disclosures contained in this Aetna HealthFund® Health Savings Account (HSA) Enrollment Package. In connection with my HSA I request an HSA debit card be issued to me, and I agree to any additional terms and conditions established by the issuing bank in connection with that card. I understand that I will receive additional Program Terms, Conditions and Disclosures that will apply with respect to my debit card. I agree to comply with all laws and regulations governing HSAs and acknowledge that Aetna, its affiliates and contractors shall not be liable for any tax or other consequences related to my establishment, funding or use of the HSA.

**X** \_\_\_\_\_  
Signature Print Name Date Signed