Health Savings Account
Employer Notification Form

If the Employer Group elects to promote Optum Bank to administer their Health Savings Accounts (HSAs), this form is to be used during implementation to gather information about their requirements for system set up.

The completed form can be emailed to hsasetup@optumbank.com or Faxed to (800) 765-6766

*** Denotes a required field. All required fields must be completed in order to avoid processing delays.**

☐ New Form ☐ Updated Form		Date Submitted: / /
Medical Policy# / Group ID# : *	**Medical Carrier / Provider:** *	
1 - Employer Information		
Employer Name: *		
Employer Address 1: *		
Employer Address 2:		
City: *	State: *	Zip Code: *
Agency Name:	Agency Tax ID #: - -	
Agency Address:		
Agency Contact Name:		
Agency Phone #: ( ) -	Agency Fax # :( ) -	Agency E-mail: **FORMTEXT**
Broker Name:	Broker ID/License #: - -	
Broker Address:		
Broker Phone #: ( ) -	Broker Fax # :( ) -	Broker E-mail: **FORMTEXT**
2 - Policy Information		
Effective Date of High Deductible Health Plan: * / /		
Estimated Number of HSAs :	HSA Sold Date: / /	
3 - Enrollment Method * **(must select one of the following as the primary enrollment method)**		
☐ Employer Portal ☐ Batch ☐ Online ☐ Paper		
Enrollment Year: *		
4 - Will Payroll deductions be deposited into the Employee's HSA? *		
☐Yes ☐No		
5 - Will Employer be contributing funds to the Employee's HSA? *		
☐Yes ☐No		

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6 - Contribution Method *(required if YES to sections 4 or 5)**	
☐ ACH Direct Deposit ☐ Combined Sum ACH/ Wire ☐ Employer Portal	
7 - Contribution Frequency *(required if YES to sections 4 or 5)**	
☐ Weekly ☐ Semi-monthly ☐ Monthly ☐ Other	
8 - Does Employer want to receive a listing of the Employee Account #'s (Account Number File / ANF) via secure email? * (required if YES to sections 4 or 5)**	
☐ Yes ☐ No	
Recipient Name:	
Phone #: ( ) -	E-mail: **FORMTEXT**
Frequency : ☐ Daily ☐ Semi-weekly ☐ Weekly ☐ Monthly	
9 - Contact Information	
1. Form Submitter: *	
Phone #: * ( ) -	E-mail: * @
2. Primary Contact (HR Contact): *	
Phone #:* ( ) -	E-mail: * @
3. Enrollment/Eligibility Contact ☐ check if same as Primary Contact (#2)	
Phone #: ( ) -	E-mail: @
4. Reporting Contact: * ☐ check if same as Primary Contact (#2)	
Phone #: * ( ) -	E-mail: * @
5. Contribution Contact: ☐ check if same as Primary Contact (#2) *(required if YES to sections 4 or 5)	
Phone #: * ( ) -	E-mail: * @
6. Payroll Vendor/System Contact: ☐ check if same as Primary Contact (#2)	
Phone #: ( ) -	E-mail: @
10 - Additional Contacts:	
Contact Name:	Contact Type:
Phone #: ( ) -	E-mail: @
Contact Name:	Contact Type:
Phone #: ( ) -	E-mail: @

Notes:

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