Communications catalog

for consumer-directed health care plans

powered by

HealthEquity®
Building Health Savings℠

This catalog is a guide to communications available for health savings account, health reimbursement arrangement and flexible spending account options administered by HealthEquity, Inc.

ABOUT BLUE CROSS BLUE SHIELD OF MICHIGAN DOCUMENTS

Each document developed by Blue Cross is identified by an alpha-numeric stock number. Contact your account manager to find out how to download or get copies of these documents.

ABOUT BLUE CARE NETWORK DOCUMENTS

Each document developed by Blue Care Network is identified by an alpha-numeric stock number. Contact your account manager to find out how to download or get copies of these documents.

ABOUT HEALTHEQUITY, INC. DOCUMENTS

Welcome kits and most forms are developed by HealthEquity. Contact your account manager to find out how to download or get copies of these documents.

HealthEquity, Inc. is an independent company supporting Blue Cross Blue Shield of Michigan by providing health care spending account administration services. An independent, FDIC-insured bank holds the health saving account dollars.

Blue Cross Blue Shield of Michigan documents

Documents in this section are developed by Blue Cross. Contact your account manager if you need copies.

Employer toolkit

Documents in this section are developed by Blue Cross. Contact your account manager if you need copies.

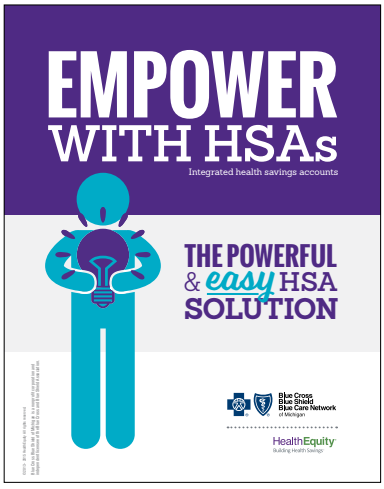
FOLDER

Title: Consumer-Directed Health Care Solutions from Blue Cross Blue Shield of Michigan and Blue Care Network – Employer Overview

Description: Pocket folder that outlines available health care spending account options and how they work with a Blue Cross or Blue Care Network health plan, includes brochures for each spending account option

Stock #: CL 15203

BROCHURES (included in folder)



Title: Empower with HSAs

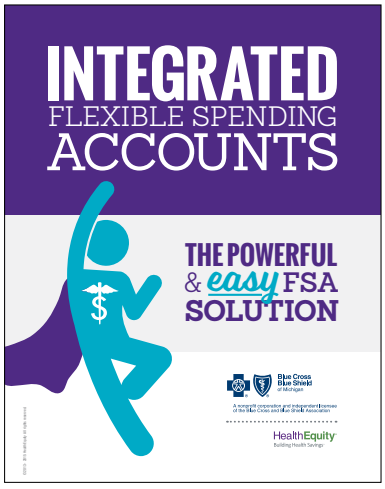
Description: Provides an overview of how an HSA works

Stock #: CF 15346

Title: Elevate your benefits with HRAs

Description: Provides an overview of how an HRA works

Stock #: CF 15347



Title: Integrated Flexible Spending Accounts

Description: Provides an overview of how an FSA works

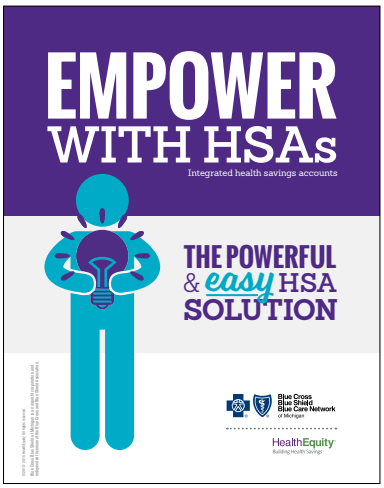
Stock #: CF 15348

HSA Communications

Documents in this section are developed by Blue Cross. Contact your account manager if you need copies.

EMPLOYER

BROCHURE

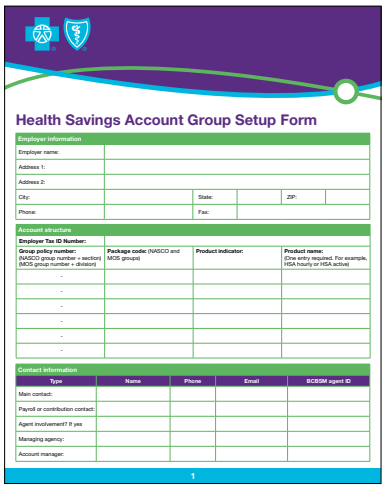


Title: Empower with HSAs

Description: Provides an overview of how an HSA works

Stock #: CF 15346

FORM



Title: Health Savings Account Group Setup Form

Description: Form used to select HSA plan features

Stock #: WP 11548

EMPLOYEE

BROCHURES

Title: Getting to know your health plan: How a health savings account works with your health plan

Description: Outlines how an HSA works with a Blue Cross health plan (presale)

Stock #: CB 14080

Title: HSA Member Manual

Description: Provides a detailed explanation of an HSA and how it works with an HSA-compatible health plan

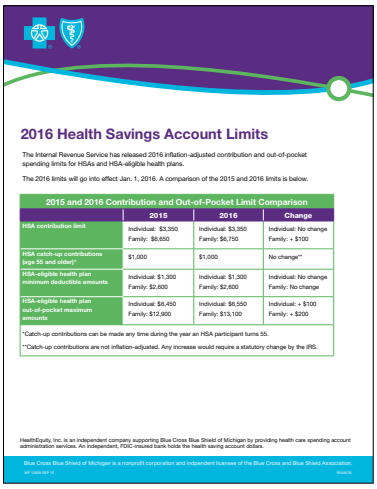
Stock #: WP 14319

HSA Communications

Documents in this section are developed by Blue Cross. Contact your account manager if you need copies.

EMPLOYEE

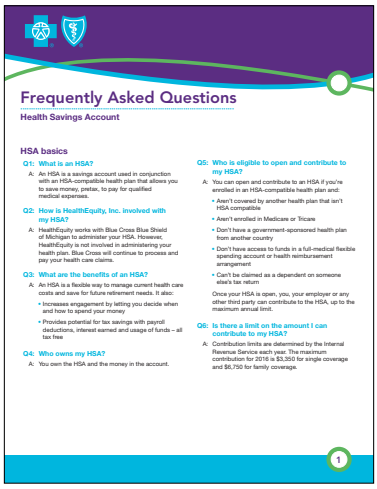
FLIERS



Title: 2016 Health Savings Account Limits

Description: A comparison of 2015 and 2016 HSA contribution and out-of-pocket limits

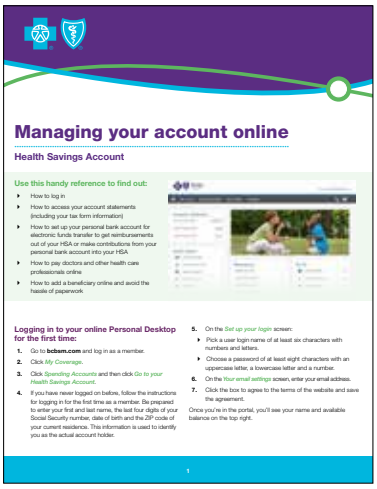
Stock #: WP 12829



Title: Frequently Asked Questions

Description: Answers questions frequently asked about HSA plans

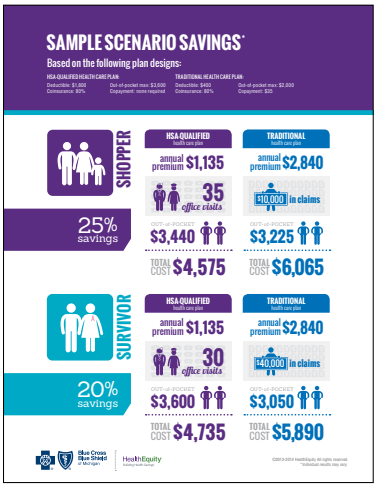
Stock #: CF 14309



Title: : Managing your account online

Description: Provides instruction on how to use the HealthEquity member portal

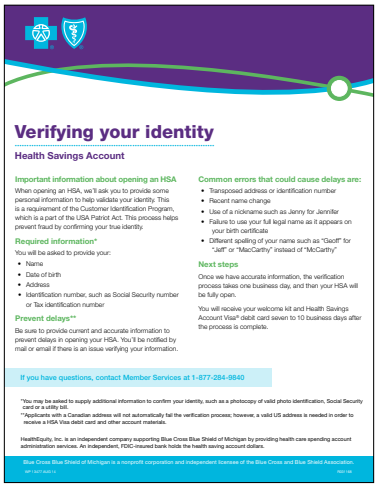
Stock #: WP 13848



Title: Sample Scenario Savings

Description: Provides examples of possible HSA savings

Stock #: OD 14310



Title: Verifying your identity

Description: Outlines the HSA identity verification process

Stock #: WP 13477

Title: : Ways to make your HSA work for You

Description: Table tent that provides examples on how an HSA can be used

HRA Communications

Documents in this section are developed by Blue Cross. Contact your account manager if you need copies.

EMPLOYER

BROCHURE

Title: Elevate your benefits with HRAs

Description: Provides an overview of how an HRA works

Stock #: CF 15347

FLIERS

Title: Health reimbursement arrangement pays first

Description: Outlines HRA pays first plan features

Stock #: WP 14306

Title: Health reimbursement arrangement plan offerings

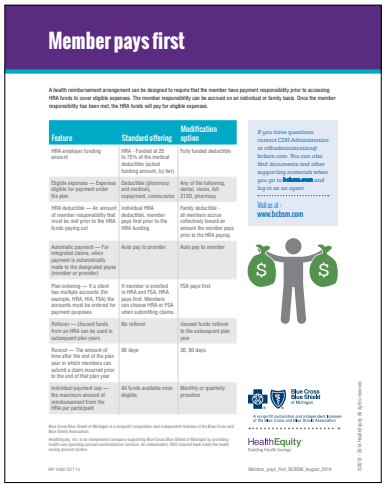
Description: Outlines available HRA plan options

Stock #: WP 14305

Title: Health reimbursement arrangement with debit card

Description: Outlines HRA with debit card plan features

Stock #: WP 14308



Title: Member pays first

Description: Outlines HRA member pays first plan features

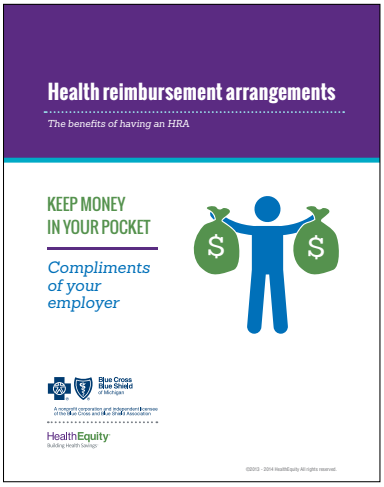
Stock #: WP 14307

HRA Communications

Documents in this section are developed by Blue Cross. Contact your account manager if you need copies.

EMPLOYEE

BROCHURE

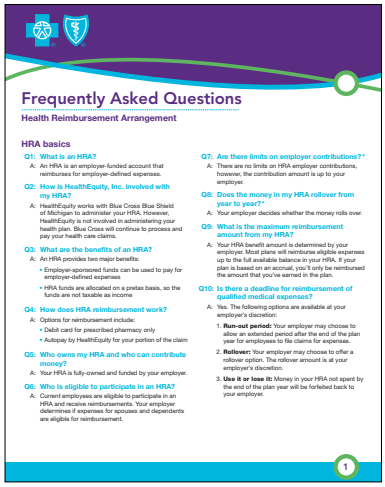


Title: The benefits of having an HRA

Description: Outlines HRA plan features (presale)

Stock #: CB 14303

FLIER



Title: Frequently Asked Questions

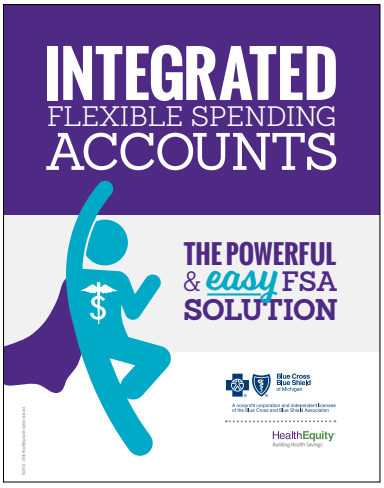
Description: Answers questions frequently asked about HRA plans

Stock #: CF 14315

FSA Communications

EMPLOYER

BROCHURE



Title: Integrated Flexible Spending Accounts

Description: Provides an overview of how an FSA works

Stock #: CF 15348

EMPLOYEE

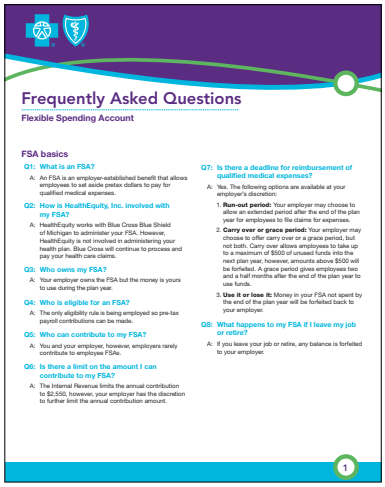
BROCHURE

Title: FSAs: A simple way to save

Description: Outlines FSA plan features (presale)

Stock #: CB 14299

FLIER



Title: Frequently Asked Questions

Description: Answers questions frequently asked about FSA plans

Stock #: CF 14300

HSA/HRA/FSA Communications

Documents in this section are developed by Blue Cross. Contact your account manager if you need copies.

EMPLOYER

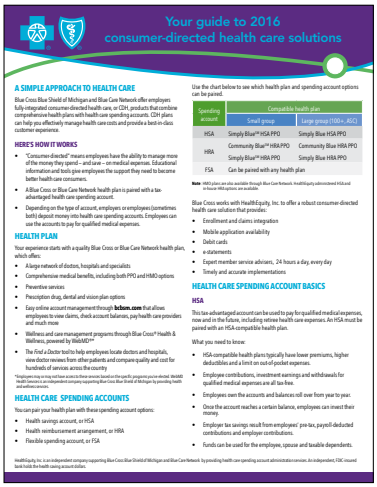
BROCHURE

Title: Consumer-directed health care solutions – Employer Guide

Description: Outlines available health care spending account options and how they work with a Blue Cross health plan

Stock #: CB 11350

FLIER

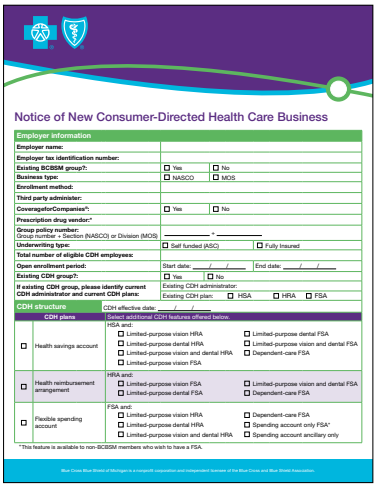


Title: Your guide to 2016 consumer-directed health care solutions

Description: Outlines available health spending account solutions and how they work with a Blue Cross health plan

Stock #: CF 15138

FORM



Title: Notice of New Consumer-Directed Health Care Business

Description: Used to establish a groups' CDH plan

Stock #: WP 11695

EMPLOYEE

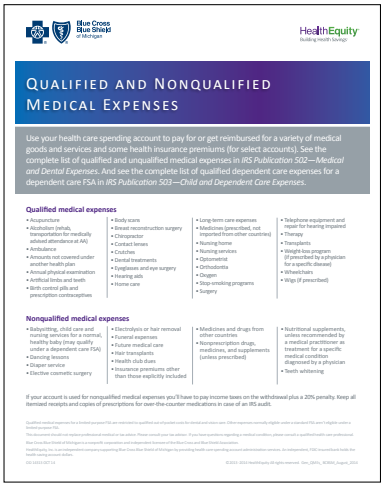
BROCHURE

Title: Getting to know your health plan. How health care spending accounts work with your health plan

Description: Outlines available health care spending account options and how they work with a Blue Cross health plan

Stock #: CB 14189

FLIER



Title: Qualified and Nonqualified Medical Expenses

Description: Outlines eligible and non-eligible health care spending account expenses

Stock #: OD 14313

Blue Care Network documents

Documents in this section are developed by Blue Care Network. Contact your account manager if you need copies.

HSA Communications

Documents in this section are developed by lue Care Network. Contact your account manager if you need copies.

EMPLOYER

BROCHURE

Title: BCN HSA HMO℠ Health Savings Account Employer Guide

Description: Provides an overview of how an HSA works

Stock #: CB 12521

EMPLOYEE

BROCHURE

Title: BCN HSA HMO℠ Health Savings Account Member Guide

Description: Outlines how an HSA works with a Blue Care Network health plan

Stock #: CB 12522

HealthEquity documents

Documents in this section are developed by HealthEquity. Contact your account manager if you need copies.

Employee Welcome Kits

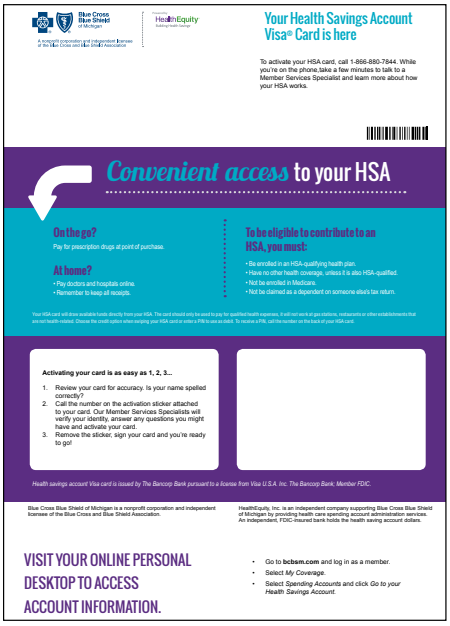
Documents in this section are developed by HealthEquity. Contact your account manager if you need copies.

HSA

HSA welcome kits are mailed directly to members' homes by HealthEquity. Welcome kits include the items noted below.

Title: Winning with an HSA

Description: Welcome kit trifold brochure mailed to employees with their debit cards when an HSA is opened



Title: Convenient access to your HSA

Description: Mailer that holds the HSA debit card

Title: Debit card

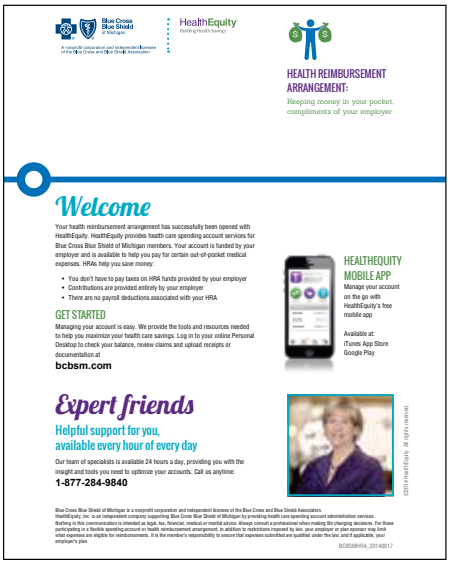
Description: Debit card members use to pay for qualified medical expenses

Employee Welcome Kits

Documents in this section are developed by HealthEquity. Contact your account manager if you need copies.

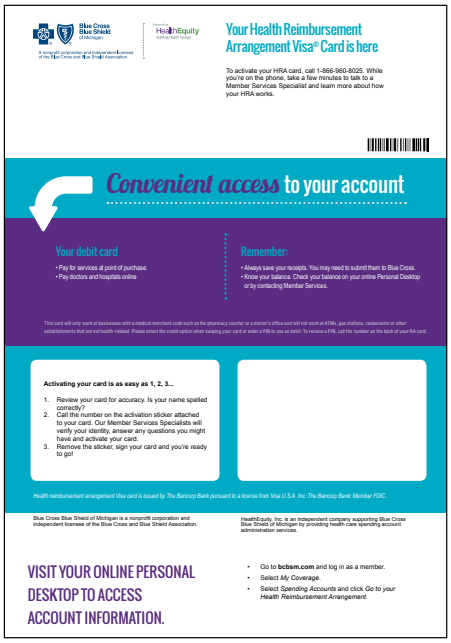
HRA

HRA welcome kits are mailed directly to members' homes by HealthEquity. Welcome kits include the items noted below.



Title: Health Reimbursement Arrangement: Keeping money in your pocket, compliments of your employer

Description: Welcome brochure mailed when an HRA is opened (if applicable)



Title: Convenient access to your account

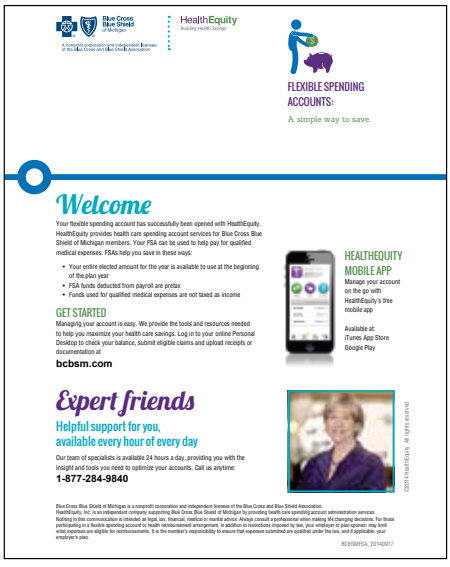
Description: Mailer that holds the HRA debit card for pharmacy expenses only

Title: Debit card

Description: Debit card members use to pay for qualified medical expenses

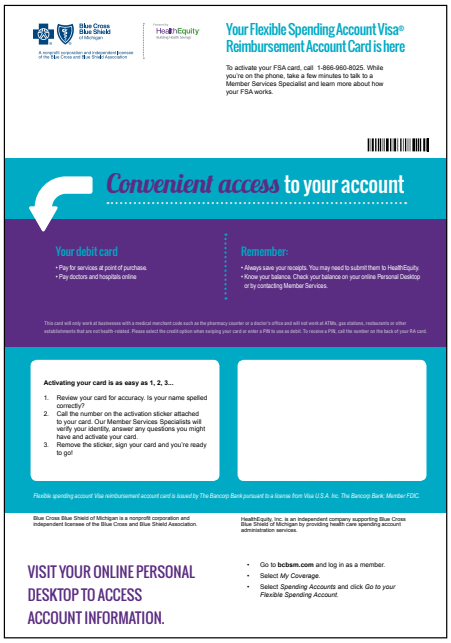
FSA

FSA welcome kits are mailed directly to members' homes by HealthEquity. Welcome kits include the items noted below.



Title: Flexible Spending Accounts: A simple way to save

Description: Welcome brochure mailed when an FSA is opened



Title: Convenient access to your account

Description: Mailer that holds the FSA debit card

Title: Debit card

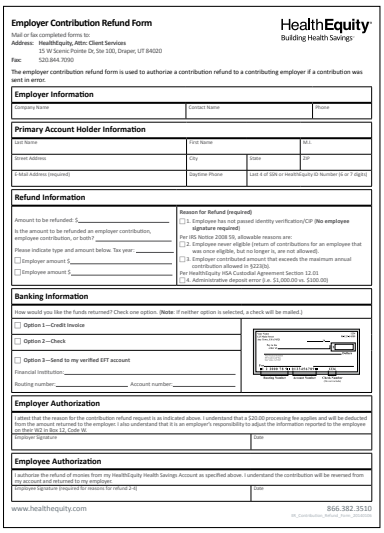
Description: Debit card members use to pay for qualified medical expenses

Forms

Documents in this section are developed by HealthEquity. Contact your account manager if you need copies.

HSA

EMPLOYER



Employer Contribution Refund Form

HealthEquity
Building Health Savings

Mail or fax completed forms to:
Address: HealthEquity, Attn: Client Services
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020
Fax: 520.844.7090

The employer contribution refund form is used to authorize a contribution refund to a contributing employer if a contribution was sent in error.

Employer Information
Company Name | Contact Name | Phone

Primary Account Holder Information
First Name | First Name | M.I.
Street Address | City | State | ZIP
E-Mail Address (required) | Daytime Phone | Last 4 of SSN or HealthEquity ID Number (4 or 7 digits)

Refund Information
Amount to be refunded: $_____
Is the amount to be refunded an employer contribution, employee contribution, or both? _____
Please indicate type and amount below. Tax year: _____
☐ Employer amount $_____
☐ Employee amount $_____

Reason for Refund (required)
☐ 1. Employee has not passed identity verification/CIP (No employee signature required)
Per IRS Notice 2008-59, allowable reasons are:
☐ 2. Employee never eligible (return of contributions for an employee that was once eligible, but no longer is, are not allowed).
☐ 3. Employer contributed amount that exceeds the maximum annual contribution allowed in §223(b).
Per HealthEquity HSA Custodial Agreement Section 12.01
☐ 4. Administrative deposit error (i.e., $1,000.00 vs. $100.00)

Banking Information
How would you like the funds returned? Check one option. (Note: If neither option is selected, a check will be mailed.)
☐ Option 1—Credit Invoice
☐ Option 2—Check
☐ Option 3—Send to my verified EFT account
Financial Institution: _____
Routing number: _____ Account number: _____

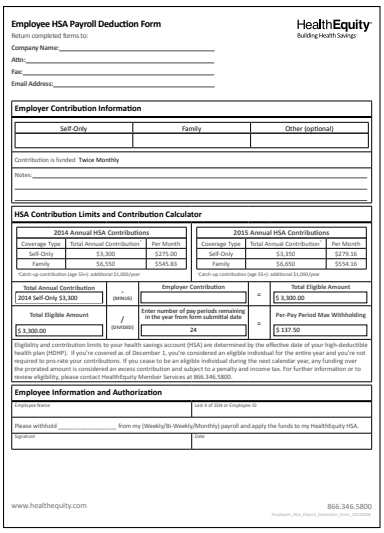
Employer Authorization
I attest that the reason for the contribution refund request is as indicated above. I understand that a $20.00 processing fee applies and will be deducted from the amount returned to the employer. I also understand that it is an employer's responsibility to adjust the information reported to the employee on their W2 in Box 12, Code W.
Employer Signature | Date

Employee Authorization
I authorize the refund of monies from my HealthEquity Health Savings Account as specified above. I understand the contribution will be reversed from my account and returned to my employer.
Employee Signature (required for reasons for refund 2-4) | Date

www.healthequity.com 866.382.3510

Title: Employer Contribution Refund Form

Description: Used to authorize a refund of employer contributions sent in error



Employee HSA Payroll Deduction Form

HealthEquity
Building Health Savings

Return completed forms to:
Company Name: _____
Attn: _____
Fax: _____
Email Address: _____

Employer Contribution Information

Self-Only	Family	Other (optional)

Contribution is funded Twice Monthly
Notes: _____

HSA Contribution Limits and Contribution Calculator

2014 Annual HSA Contributions		
Coverage Type	Total Annual Contribution	Per Month
Self-Only	$3,300	$275.00
Family	$6,550	$545.83

*Catch-up contribution (age 55+): additional $1,000/year

2015 Annual HSA Contributions		
Coverage Type	Total Annual Contribution	Per Month
Self-Only	$3,350	$279.16
Family	$6,650	$554.16

*Catch-up contribution (age 55+): additional $1,000/year

Total Annual Contribution (2014 Self-Only $3,300) − (MINUS) Employer Contribution = Total Eligible Amount ($ 3,300.00)
Total Eligible Amount ($ 3,300.00) / (DIVIDED) Enter number of pay periods remaining in the year from form submittal date (24) = Per-Pay Period Max Withholding ($ 137.50)

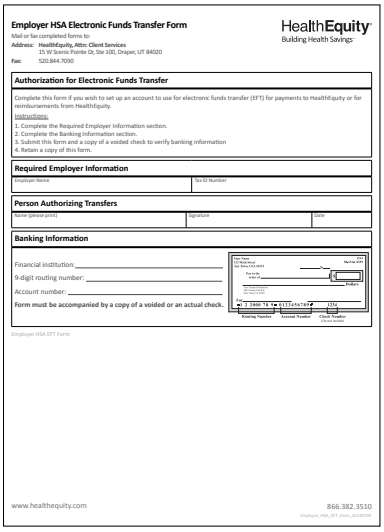
Eligibility and contribution limits to your health savings account (HSA) are determined by the effective date of your high-deductible health plan (HDHP). If you're covered as of December 1, you're considered an eligible individual for the entire year and you're not required to pro-rate your contributions. If you cease to be an eligible individual during the next calendar year, any funding over the prorated amount is considered an excess contribution and subject to a penalty and income tax. For further information or to review eligibility, please contact HealthEquity Member Services at 866.346.5800.

Employee Information and Authorization
Employee Name | Last 4 of SSN or Employee ID
Please withhold _____ from my (Weekly/Bi-Weekly/Monthly) payroll and apply the funds to my HealthEquity HSA.
Signature | Date

www.healthequity.com 866.346.5800

Title: Employee HSA Payroll Deduction Form

Description: Used to determine and elect employee payroll deduction amounts



Employer HSA Electronic Funds Transfer Form

HealthEquity
Building Health Savings

Mail or fax completed forms to:
Address: HealthEquity, Attn: Client Services
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020
Fax: 520.844.7090

Authorization for Electronic Funds Transfer
Complete this form if you wish to set up an account to use for electronic funds transfer (EFT) for payments to HealthEquity or for reimbursements from HealthEquity.
Instructions:
1. Complete the Required Employer Information section.
2. Complete the Banking Information section.
3. Submit this form and a copy of a voided check to verify banking information
4. Retain a copy of this form.

Required Employer Information
Employer Name | Tax ID Number

Person Authorizing Transfers
Name (please print) | Signature | Date

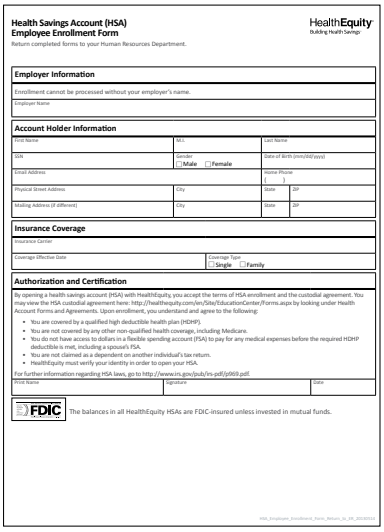
Banking Information
Financial institution: _____
9-digit routing number: _____
Account number: _____
Form must be accompanied by a copy of a voided or an actual check.

Employer HSA EFT Form

www.healthequity.com 866.382.3510

Title: Employer HSA Electronic Funds Transfer Form

Description: Used to set up electronic funds transfer for payments to or reimbursements from HealthEquity



Health Savings Account (HSA)
Employee Enrollment Form

HealthEquity
Building Health Savings

Return completed forms to your Human Resources Department.

Employer Information
Enrollment cannot be processed without your employer's name.
Employer Name

Account Holder Information
First Name | M.I. | Last Name
SSN | Gender ☐ Male ☐ Female | Date of Birth (mm/dd/yyyy)
Email Address | Home Phone ( )
Physical Street Address | City | State | ZIP
Mailing Address (if different) | City | State | ZIP

Insurance Coverage
Insurance Carrier
Coverage Effective Date | Coverage Type ☐ Single ☐ Family

Authorization and Certification
By opening a health savings account (HSA) with HealthEquity, you accept the terms of HSA enrollment and the custodial agreement. You may view the HSA custodial agreement here: http://healthequity.com/en/Site/EducationCenter/Forms.aspx by looking under Health Account Forms and Agreements. Upon enrollment, you understand and agree to the following:

- You are covered by a qualified high deductible health plan (HDHP).
- You are not covered by any other non-qualified health coverage, including Medicare.
- You do not have access to dollars in a flexible spending account (FSA) to pay for any medical expenses before the required HDHP deductible is met, including a spouse's FSA.
- You are not claimed as a dependent on another individual's tax return.
- HealthEquity must verify your identity in order to open your HSA.

For further information regarding HSA laws, go to http://www.irs.gov/pub/irs-pdf/p969.pdf.

First Name | Signature | Date

FDIC The balances in all HealthEquity HSAs are FDIC-insured unless invested in mutual funds.

Title: Health Savings Account (HSA) Employee Enrollment Form

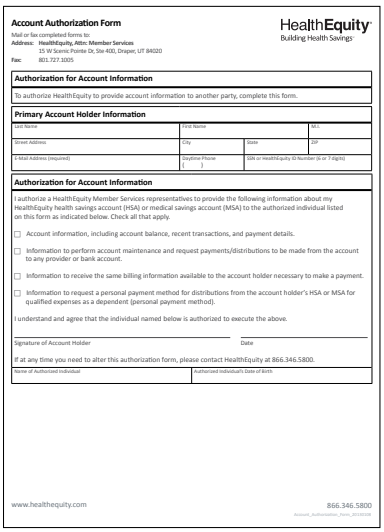
Description: Used to enroll in an HSA

Forms

Documents in this section are developed by HealthEquity. Contact your account manager if you need copies.

HSA

EMPLOYEE


Account Authorization Form

Mail or fax completed forms to:
Address: HealthEquity, Attn: Member Services
15 W Scenic Pointe Dr, Ste 400, Draper, UT 84020
Fax: 801.727.1005

Authorization for Account Information

To authorize HealthEquity to provide account information to another party, complete this form.

Primary Account Holder Information

Last Name | First Name | M.I.
Street Address | City | State | ZIP
E-Mail Address (required) | Daytime Phone | SSN or HealthEquity ID Number (6 or 7 digits)

Authorization for Account Information

I authorize a HealthEquity Member Services representatives to provide the following information about my HealthEquity health savings account (HSA) or medical savings account (MSA) to the authorized individual listed on this form as indicated below. Check all that apply.

- Account information, including account balance, recent transactions, and payment details.
- Information to perform account maintenance and request payments/distributions to be made from the account to any provider or bank account.
- Information to receive the same billing information available to the account holder necessary to make a payment.
- Information to request a personal payment method for distributions from the account holder's HSA or MSA for qualified expenses as a dependent (personal payment method).

I understand and agree that the individual named below is authorized to execute the above.

Signature of Account Holder | Date

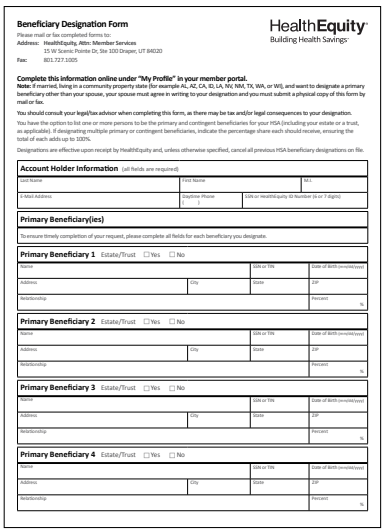
If at any time you need to alter this authorization form, please contact HealthEquity at 866.346.5800.

Name of Authorized Individual | Authorized Individual's Date of Birth

www.healthequity.com 866.346.5800

Title: Account Authorization Form

Description: Used to authorize HealthEquity to release account information to a third party


Beneficiary Designation Form

Please mail or fax completed forms to:
Address: HealthEquity, Attn: Member Services
15 W Scenic Pointe Dr, Ste 100 Draper, UT 84020
Fax: 801.727.1005

Complete this information online under "My Profile" in your member portal.
Note: If married, living in a community property state (for example AL, AZ, CA, ID, LA, NV, NM, TX, WA, or WI), and want to designate a primary beneficiary other than your spouse, your spouse must agree in writing to your designation and you must submit a physical copy of this form by mail or fax.

You should consult your legal/tax advisor when completing this form, as there may be tax and/or legal consequences to your designation.

You have the option to list one or more persons to be the primary and contingent beneficiaries for your HSA (including your estate or a trust, as applicable). If designating multiple primary or contingent beneficiaries, indicate the percentage share each should receive, ensuring the total of each adds up to 100%.

Designations are effective upon receipt by HealthEquity and, unless otherwise specified, cancel all previous HSA beneficiary designations on file.

Account Holder Information (all fields are required)

Last Name | First Name | M.I.
E-Mail Address | Daytime Phone | SSN or HealthEquity ID Number (6 or 7 digits)

Primary Beneficiary(ies)

To ensure timely completion of your request, please complete all fields for each beneficiary you designate.

Primary Beneficiary 1 Estate/Trust ☐ Yes ☐ No
Name | SSN or TIN | Date of Birth (mm/dd/yyyy)
Address | City | State | ZIP
Relationship | Percent %

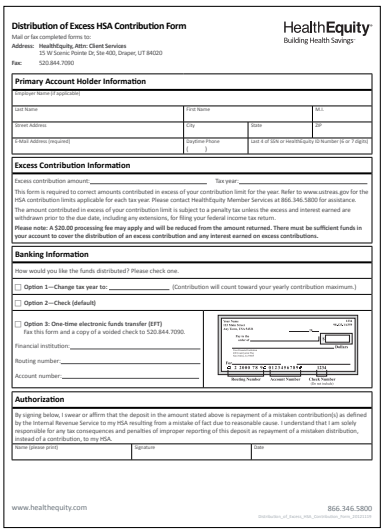
Primary Beneficiary 2 Estate/Trust ☐ Yes ☐ No
Name | SSN or TIN | Date of Birth (mm/dd/yyyy)
Address | City | State | ZIP
Relationship | Percent %

Primary Beneficiary 3 Estate/Trust ☐ Yes ☐ No
Name | SSN or TIN | Date of Birth (mm/dd/yyyy)
Address | City | State | ZIP
Relationship | Percent %

Primary Beneficiary 4 Estate/Trust ☐ Yes ☐ No
Name | SSN or TIN | Date of Birth (mm/dd/yyyy)
Address | City | State | ZIP
Relationship | Percent %

Title: Beneficiary Designation form

Description: Used to elect beneficiaries


Distribution of Excess HSA Contribution Form

Mail or fax completed forms to:
Address: HealthEquity, Attn: Client Services
15 W Scenic Pointe Dr, Ste 400, Draper, UT 84020
Fax: 520.844.7090

Primary Account Holder Information

Employer Name (if applicable)
Last Name | First Name | M.I.
Street Address | City | State | ZIP
E-Mail Address (required) | Daytime Phone | Last 4 of SSN or HealthEquity ID Number (6 or 7 digits)

Excess Contribution Information

Excess contribution amount: _____ Tax year: _____

This form is required to correct amounts contributed in excess of your contribution limit for the year. Refer to www.ustreas.gov for the HSA contribution limits applicable for each tax year. Please contact HealthEquity Member Services at 866.346.5800 for assistance. The amount contributed in excess of your contribution limit is subject to a penalty tax unless the excess and interest earned are withdrawn prior to the due date, including any extensions, for filing your federal income tax return.

Please note: A $20.00 processing fee may apply and will be reduced from the amount returned. There must be sufficient funds in your account to cover the distribution of an excess contribution and any interest earned on excess contributions.

Banking Information

How would you like the funds distributed? Please check one.

☐ Option 1—Change tax year to: _____ (Contribution will count toward your yearly contribution maximum.)

☐ Option 2—Check (default)

☐ Option 3: One-time electronic funds transfer (EFT)
Fax this form and a copy of a voided check to 520.844.7090.
Financial institution: _____
Routing number: _____
Account number: _____

Authorization

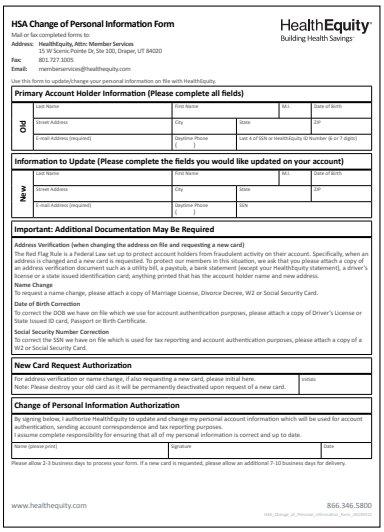
By signing below, I swear or affirm that the deposit in the amount stated above is repayment of a mistaken contribution(s) as defined by the Internal Revenue Service to my HSA resulting from a mistake of fact due to reasonable cause. I understand that I am solely responsible for any tax consequences and penalties of improper reporting of this deposit as repayment of a mistaken distribution, instead of a contribution, to my HSA.

Name (please print) | Signature | Date

www.healthequity.com 866.346.5800

Title: Distribution of Excess HSA Contribution Form

Description: Used to correct amounts contributed in excess of the yearly contribution limit


HSA Change of Personal Information Form

Mail or fax completed forms to:
Address: HealthEquity, Attn: Member Services
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020
Fax: 801.727.1005
Email: memberservices@healthequity.com

Use this form to update/change your personal information on file with HealthEquity.

Primary Account Holder Information (Please complete all fields)

Old
Last Name | First Name | M.I. | Date of Birth
Street Address | City | State | ZIP
E-mail Address (required) | Daytime Phone | Last 4 of SSN or HealthEquity ID Number (6 or 7 digits)

Information to Update (Please complete the fields you would like updated on your account)

New
Last Name | First Name | M.I. | Date of Birth
Street Address | City | State | ZIP
E-mail Address (required) | Daytime Phone | SSN

Important: Additional Documentation May Be Required

Address Verification (when changing the address on file and requesting a new card)
The Red Flag Rule is a Federal Law set up to protect account holders from fraudulent activity on their account. Specifically, when an address is changed and a new card is requested. To protect our members in this situation, we ask that you please attach a copy of an address verification document such as a utility bill, a paystub, a bank statement (except your HealthEquity statement), a driver's license or a state issued identification card; anything printed that has the account holder name and new address.

Name Change
To request a name change, please attach a copy of Marriage License, Divorce Decree, W2 or Social Security Card.

Date of Birth Correction
To correct the DOB we have on file which we use for account authentication purposes, please attach a copy of Driver's License or State Issued ID card, Passport or Birth Certificate.

Social Security Number Correction
To correct the SSN we have on file which is used for tax reporting and account authentication purposes, please attach a copy of a W2 or Social Security Card.

New Card Request Authorization

For address verification or name change, if also requesting a new card, please initial here. Initials
Note: Please destroy your old card as it will be permanently deactivated upon request of a new card.

Change of Personal Information Authorization

By signing below, I authorize HealthEquity to update and change my personal account information which will be used for account authentication, sending account correspondence and tax reporting purposes.
I assume complete responsibility for ensuring that all of my personal information is correct and up to date.

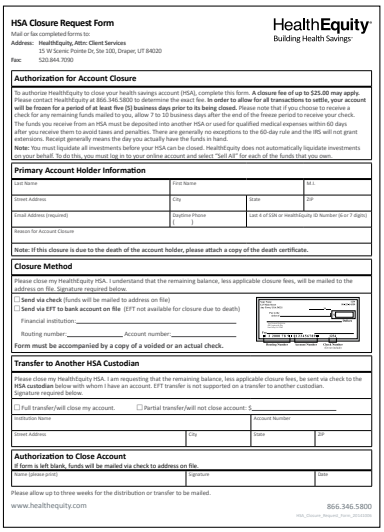
Name (please print) | Signature | Date

Please allow 2-3 business days to process your form. If a new card is requested, please allow an additional 7-10 business days for delivery.

www.healthequity.com 866.346.5800

Title: HSA Change of Personal Information Form

Description: Used to update or change personal information on file with HealthEquity


HSA Closure Request Form

Mail or fax completed forms to:
Address: HealthEquity, Attn: Client Services
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020
Fax: 520.844.7090

Authorization for Account Closure

To authorize HealthEquity to close your health savings account (HSA), complete this form. A closure fee of up to $25.00 may apply. Please contact HealthEquity at 866.346.5800 to determine the exact fee. In order to allow for all transactions to settle, your account will be frozen for a period of at least five (5) business days prior to its being closed. Please note that if you choose to receive a check for any remaining funds mailed to you, allow 7 to 10 business days after the end of the freeze period to receive your check. The funds you receive from an HSA must be deposited into another HSA or used for qualified medical expenses within 60 days after you receive them to avoid taxes and penalties. There are generally no exceptions to the 60-day rule and the IRS will not grant extensions. Receipt generally means the day you actually have the funds in hand.
Note: You must liquidate all investments before your HSA can be closed. HealthEquity does not automatically liquidate investments on your behalf. To do this, you must log in to your online account and select "Sell All" for each of the funds that you own.

Primary Account Holder Information

Last Name | First Name | M.I.
Street Address | City | State | ZIP
E-mail Address (required) | Daytime Phone | Last 4 of SSN or HealthEquity ID Number (6 or 7 digits)
Reason for Account Closure

Note: If this closure is due to the death of the account holder, please attach a copy of the death certificate.

Closure Method

Please close my HealthEquity HSA. I understand that the remaining balance, less applicable closure fees, will be mailed to the address on file. Signature required below.

☐ Send via check (funds will be mailed to address on file)
☐ Send via EFT to bank account on file (EFT not available for closure due to death)
Financial institution: _____
Routing number: _____ Account number: _____
Form must be accompanied by a copy of a voided or an actual check.

Transfer to Another HSA Custodian

Please close my HealthEquity HSA. I am requesting that the remaining balance, less applicable closure fees, be sent via check to the HSA custodian below with whom I have an account. EFT transfer is not supported on a transfer to another custodian. Signature required below.

☐ Full transfer/will close my account. ☐ Partial transfer/will not close account: $_____
Institution Name | Account Number
Street Address | City | State | ZIP

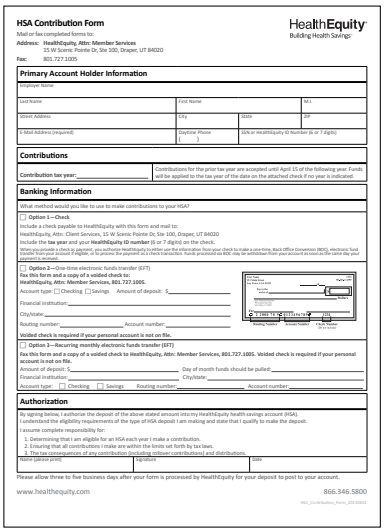
Authorization to Close Account
If form is left blank, funds will be mailed via check to address on file.
Name (please print) | Signature | Date

Please allow up to three weeks for the distribution or transfer to be mailed.

www.healthequity.com 866.346.5800

Title: HSA Closure Request form

Description: Used to authorize HealthEquity to close an HSA


HSA Contribution Form

Mail or fax completed forms to:
Address: HealthEquity, Attn: Member Services
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020
Fax: 801.727.1005

Primary Account Holder Information

Employer Name
Last Name | First Name | M.I.
Street Address | City | State | ZIP
E-Mail Address (required) | Daytime Phone | SSN or HealthEquity ID Number (6 or 7 digits)

Contributions

Contribution tax year: _____ Contributions for the prior tax year are accepted until April 15 of the following year. Funds will be applied to the tax year of the date on the attached check if no year is indicated.

Banking Information

What method would you like to use to make contributions to your HSA?

☐ Option 1—Check
Include a check payable to HealthEquity with this form and mail to:
HealthEquity, Attn: Client Services, 15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020
Include the tax year and your HealthEquity ID number (6 or 7 digits) on the check.
When you provide a check as payment, you authorize HealthEquity to either use the information from your check to make a one-time, Bank Office Conversion (BOC), electronic fund transfer (EFT) from your account or to process the payment as a check transaction. When processed as EFT, funds may be withdrawn from your account as soon as the same day your payment is received.

☐ Option 2—One-time electronic funds transfer (EFT)
Fax this form and a copy of a voided check to:
HealthEquity, Attn: Member Services, 801.727.1005.
Account type: ☐ Checking ☐ Savings Amount of deposit: $_____
Financial institution: _____
City/state: _____
Routing number: _____ Account number: _____
Voided check is required if your personal account is not on file.

☐ Option 3—Recurring monthly electronic funds transfer (EFT)
Fax this form and a copy of a voided check to HealthEquity, Attn: Member Services, 801.727.1005. Voided check is required if your personal account is not on file.
Amount of deposit: $_____ Day of month funds should be pulled: _____
Financial institution: _____ City/state: _____
Account type: ☐ Checking ☐ Savings Routing number: _____ Account number: _____

Authorization

By signing below, I authorize the deposit of the above stated amount into my HealthEquity health savings account (HSA).
I understand the eligibility requirements of the type of HSA deposit I am making and state that I qualify to make the deposit.
I assume complete responsibility for:
1. Determining that I am eligible for an HSA each year I make a contribution.
2. Ensuring that all contributions I make are within the limits set forth by tax laws.
3. The tax consequences of any contribution (including rollover contributions) and distributions.

Name (please print) | Signature | Date

Please allow three to five business days after your form is processed by HealthEquity for your deposit to post to your account.

www.healthequity.com 866.346.5800

Title: HSA Contribution Form

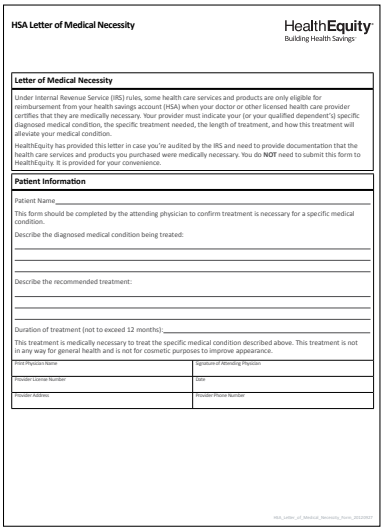
Description: Used to designate employee HSA contribution method

Forms

Documents in this section are developed by HealthEquity. Contact your account manager if you need copies.

HSA

EMPLOYEE


HSA Letter of Medical Necessity

HealthEquity
Building Health Savings

Letter of Medical Necessity

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your health savings account (HSA) when your doctor or other licensed health care provider certifies that they are medically necessary. Your provider must indicate your (or your qualified dependent's) specific diagnosed medical condition, the specific treatment needed, the length of treatment, and how this treatment will alleviate your medical condition.

HealthEquity has provided this letter in case you're audited by the IRS and need to provide documentation that the health care services and products you purchased were medically necessary. You do **NOT** need to submit this form to HealthEquity. It is provided for your convenience.

Patient Information

Patient Name_____

This form should be completed by the attending physician to confirm treatment is necessary for a specific medical condition.

Describe the diagnosed medical condition being treated:

Describe the recommended treatment:

Duration of treatment (not to exceed 12 months):_____

This treatment is medically necessary to treat the specific medical condition described above. This treatment is not in any way for general health and is not for cosmetic purposes to improve appearance.

Print Physician Name | Signature of Attending Physician

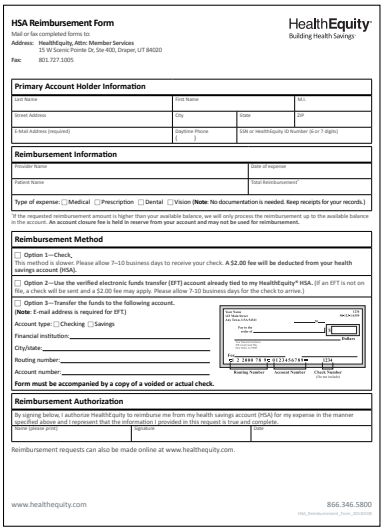
Provider License Number | Date

Provider Address | Provider Phone Number

HSA_Letter_of_Medical_Necessity_Form_20220523

Title: HSA Letter of Medical Necessity

Description: Used to substantiate purchases made with HSA funds


HSA Reimbursement Form

HealthEquity
Building Health Savings

Mail or fax completed forms to:
Address: HealthEquity, Attn: Member Services
15 W Scenic Pointe Dr, Ste 400, Draper, UT 84020
Fax: 801.727.1005

Primary Account Holder Information

Last Name | First Name | M.I.

Street Address | City | State | ZIP

E-Mail Address (required) | Daytime Phone ( ) | SSN or HealthEquity ID Number (6 or 7 digits)

Reimbursement Information

Provider Name | Date of expense

Patient Name | Total Reimbursement*

Type of expense: ☐Medical ☐Prescription ☐Dental ☐Vision (Note: No documentation is needed. Keep receipts for your records.)

* If the requested reimbursement amount is higher than your available balance, we will only process the reimbursement up to the available balance in the account. An account closure fee is held in reserve from your account and may not be used for reimbursement.

Reimbursement Method

☐ Option 1—Check.
This method is slower. Please allow 7–10 business days to receive your check. A $2.00 fee will be deducted from your health savings account (HSA).

☐ Option 2—Use the verified electronic funds transfer (EFT) account already tied to my HealthEquity® HSA. (If an EFT is not on file, a check will be sent and a $2.00 fee may apply. Please allow 7-10 business days for the check to arrive.)

☐ Option 3—Transfer the funds to the following account.
(Note: E-mail address is required for EFT.)
Account type: ☐Checking ☐Savings
Financial institution:_____
City/state:_____
Routing number:_____
Account number:_____
Form must be accompanied by a copy of a voided or actual check.

Reimbursement Authorization

By signing below, I authorize HealthEquity to reimburse me from my health savings account (HSA) for my expense in the manner specified above and I represent that the information I provided in this request is true and complete.

Name (please print) | Signature | Date

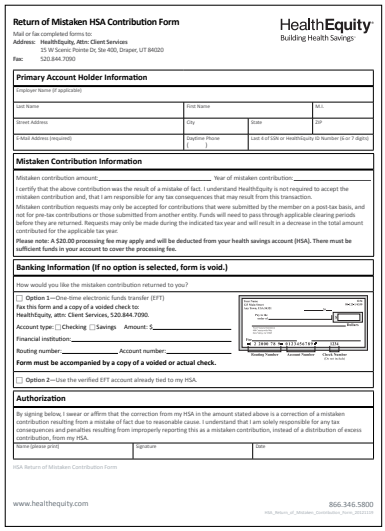
Reimbursement requests can also be made online at www.healthequity.com.

www.healthequity.com 866.346.5800

HSA_Reimbursement_Form_20220328

Title: HSA Reimbursement Form

Description: Used to request reimbursement for qualified medical expenses


Return of Mistaken HSA Contribution Form

HealthEquity
Building Health Savings

Mail or fax completed forms to:
Address: HealthEquity, Attn: Client Services
15 W Scenic Pointe Dr, Ste 400, Draper, UT 84020
Fax: 520.844.7090

Primary Account Holder Information

Employer Name (if applicable)

Last Name | First Name | M.I.

Street Address | City | State | ZIP

E-Mail Address (required) | Daytime Phone ( ) | Last 4 of SSN or HealthEquity ID Number (6 or 7 digits)

Mistaken Contribution Information

Mistaken contribution amount:_____ Year of mistaken contribution:_____

I certify that the above contribution was the result of a mistake of fact. I understand HealthEquity is not required to accept the mistaken contribution and, that I am responsible for any tax consequences that may result from this transaction.

Mistaken contribution requests may only be accepted for contributions that were submitted by the member on a post-tax basis, and not for pre-tax contributions or those submitted from another entity. Funds will need to pass through applicable clearing periods before they are returned. Requests may only be made during the indicated tax year and will result in a decrease in the total amount contributed for the applicable tax year.

Please note: A $20.00 processing fee may apply and will be deducted from your health savings account (HSA). There must be sufficient funds in your account to cover the processing fee.

Banking Information (If no option is selected, form is void.)

How would you like the mistaken contribution returned to you?

☐ Option 1—One-time electronic funds transfer (EFT)
Fax this form and a copy of a voided check to:
HealthEquity, attn: Client Services, 520.844.7090.
Account type: ☐Checking ☐Savings Amount: $_____
Financial institution:_____
Routing number:_____ Account number:_____
Form must be accompanied by a copy of a voided or actual check.

☐ Option 2—Use the verified EFT account already tied to my HSA.

Authorization

By signing below, I swear or affirm that the correction from my HSA in the amount stated above is a correction of a mistaken contribution resulting from a mistake of fact due to reasonable cause. I understand that I am solely responsible for any tax consequences and penalties resulting from improperly reporting this as a mistaken contribution, instead of a distribution of excess contribution, from my HSA.

Name (please print) | Signature | Date

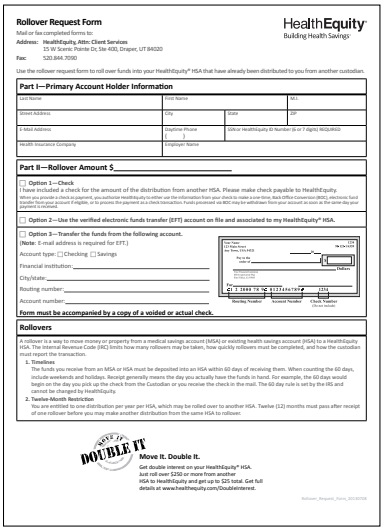
HSA Return of Mistaken Contribution Form

www.healthequity.com 866.346.5800

HSA_Return_of_Mistaken_Contribution_Form_20220328

Title: Return of Mistaken HSA Contribution Form

Description: Used to request return of mistaken contribution amounts


Rollover Request Form

HealthEquity
Building Health Savings

Mail or fax completed forms to:
Address: HealthEquity, Attn: Client Services
15 W Scenic Pointe Dr, Ste 400, Draper, UT 84020
Fax: 520.844.7090

Use the rollover request form to roll over funds into your HealthEquity® HSA that have already been distributed to you from another custodian.

Part I—Primary Account Holder Information

Last Name | First Name | M.I.

Street Address | City | State | ZIP

E-Mail Address | Daytime Phone ( ) | SSN or HealthEquity ID Number (6 or 7 digits) REQUIRED

Health Insurance Company | Employer Name

Part II—Rollover Amount $_____

☐ Option 1—Check
I have included a check for the amount of the distribution from another HSA. Please make check payable to HealthEquity.
Where you provide a check as payment, you authorize HealthEquity to either use the information from your check to make a one-time, Back Office Conversion (BOC), electronic fund payment to be debited from your account if eligible, or to process the payment as a check transaction. Funds processed via ACH may be withdrawn from your account as soon as the same day your payment is received.

☐ Option 2—Use the verified electronic funds transfer (EFT) account on file and associated to my HealthEquity® HSA.

☐ Option 3—Transfer the funds from the following account.
(Note: E-mail address is required for EFT.)
Account type: ☐Checking ☐Savings
Financial institution:_____
City/state:_____
Routing number:_____
Account number:_____
Form must be accompanied by a copy of a voided or actual check.

Rollovers

A rollover is a way to move money or property from a medical savings account (MSA) or existing health savings account (HSA) to a HealthEquity HSA. The Internal Revenue Code (IRC) limits how many rollovers may be taken, how quickly rollovers must be completed, and how the custodian must report the transaction.

1. Timelines
The funds you receive from an MSA or HSA must be deposited into an HSA within 60 days of receiving them. When counting the 60 days, include weekends and holidays. Receipt generally means the day you actually have the funds in hand. For example, the 60 days would begin on the day you pick up the check from the Custodian or you receive the check in the mail. The 60-day rule is set by the IRS and cannot be changed by HealthEquity.
2. Twelve-Month Restriction
You are entitled to one distribution per year per HSA, which may be rolled over to another HSA. Twelve (12) months must pass after receipt of one rollover before you may make another distribution from the same HSA to rollover.

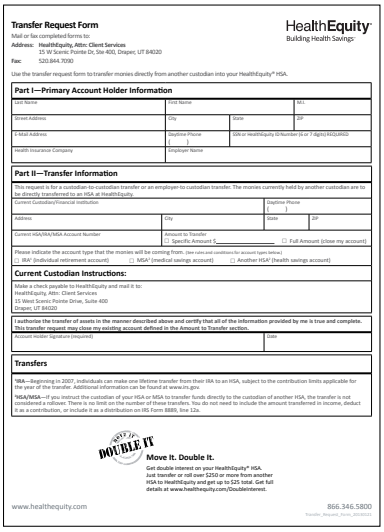
DOUBLE IT

Move It. Double It.
Get double interest on your HealthEquity® HSA.
Just roll over $250 or more from another HSA to HealthEquity and get up to $25 total. Get full details at www.healthequity.com/DoubleInterest.

Rollover_Request_Form_20220708

Title: Rollover Request Form

Description: Used to roll over funds distributed by another custodian into a HealthEquity HSA


Transfer Request Form

HealthEquity
Building Health Savings

Mail or fax completed forms to:
Address: HealthEquity, Attn: Client Services
15 W Scenic Pointe Dr, Ste 400, Draper, UT 84020
Fax: 520.844.7090

Use the transfer request form to transfer monies directly from another custodian into your HealthEquity® HSA.

Part I—Primary Account Holder Information

Last Name | First Name | M.I.

Street Address | City | State | ZIP

E-Mail Address | Daytime Phone ( ) | SSN or HealthEquity ID Number (6 or 7 digits) REQUIRED

Health Insurance Company | Employer Name

Part II—Transfer Information

This request is for a custodian-to-custodian transfer or an employer-to-custodian transfer. The monies currently held by another custodian are to be directly transferred to an HSA at HealthEquity.

Current Custodian/Financial Institution | Daytime Phone ( )

Address | City | State | ZIP

Current HSA/IRA/MSA Account Number | Amount to Transfer ☐ Specific Amount $_____ ☐ Full Amount (close my account)

Please indicate the account type that the monies will be coming from. (See rules and conditions for account types below.)
☐ IRA* (individual retirement account) ☐ MSA* (medical savings account) ☐ Another HSA* (health savings account)

Current Custodian Instructions:

Make a check payable to HealthEquity and mail it to:
HealthEquity, Attn: Client Services
15 West Scenic Pointe Drive, Suite 400
Draper, UT 84020

I authorize the transfer of assets in the manner described above and certify that all of the information provided by me is true and complete. This transfer request may close my existing account defined in the Amount to Transfer section.

Account Holder Signature (required) | Date

Transfers

*IRA—Beginning in 2007, individuals can make one lifetime transfer from their IRA to an HSA, subject to the contribution limits applicable for the year of the transfer. Additional information can be found at www.irs.gov.

*MSA/HSA—If you instruct the custodian of your MSA or HSA to transfer funds directly to the custodian of another HSA, the transfer is not considered a rollover. There is no limit on the number of these transfers. You do not need to include the amount transferred in income, deduct it as a contribution, or include it as a distribution on IRS Form 8889, line 12a.

DOUBLE IT

Move It. Double It.
Get double interest on your HealthEquity® HSA.
Just transfer or roll over $250 or more from another HSA to HealthEquity and get up to $25 total. Get full details at www.healthequity.com/DoubleInterest.

www.healthequity.com 866.346.5800

Transfer_Request_Form_20220222

Title: Transfer Request Form

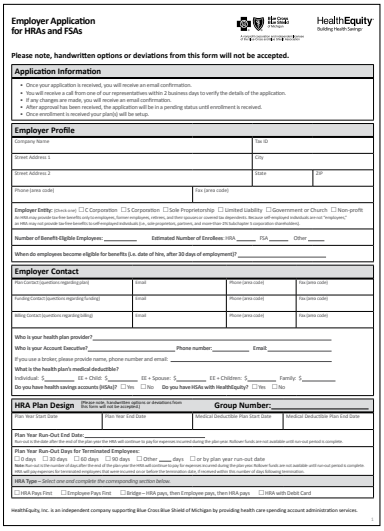
Description: Used to transfer funds from another custodian directly into a HealthEquity HSA

Forms

Documents in this section are developed by HealthEquity. Contact your account manager if you need copies.

HRA/FSA

EMPLOYER


Employer Application for HRAs and FSAs

HealthEquity Building Health Savings

Please note, handwritten options or deviations from this form will not be accepted.

Application Information

- Once your application is received, you will receive an email confirmation.
- You will receive a call from one of our representatives within 2 business days to verify the details of the application.
- If any changes are made, you will receive an email confirmation.
- After approval has been received, the application will be in a pending status until enrollment is received.
- Once enrollment is received your plan(s) will be setup.

Employer Profile

Company Name | Tax ID
Street Address 1 | City
Street Address 2 | State | ZIP
Phone (area code) | Fax (area code)

Employer Entity: (Check one) ☐ C Corporation ☐ S Corporation ☐ Sole Proprietorship ☐ Limited Liability ☐ Government or Church ☐ Non-profit

As HRA may provide tax-free benefits only to employees, former employees, retirees, and their spouses or covered tax dependents. Because self-employed individuals are not "employees," an HRA may not provide tax-free benefits to self-employed individuals (i.e., sole proprietors, partners, and more than 2% shareholder-S corporation shareholders).

Number of Benefit-Eligible Employees: _____ Estimated Number of Enrollees: HRA _____ FSA _____ Other _____

When do employees become eligible for benefits (i.e. date of hire, after 30 days of employment)? _____

Employer Contact

Plan Contact (questions regarding plan) | Email | Phone (area code) | Fax (area code)
Funding Contact (questions regarding funding) | Email | Phone (area code) | Fax (area code)
Billing Contact (questions regarding billing) | Email | Phone (area code) | Fax (area code)

Who is your health plan provider? _____
Who is your Account Executive? _____ Phone number: _____ Email: _____
If you use a broker, please provide name, phone number and email: _____
What is the health plan's medical deductible?
Individual: $_____ EE + Child: $_____ EE + Spouse: $_____ EE + Children: $_____ Family: $_____
Do you have health savings accounts (HSAs)? ☐ Yes ☐ No Do you have HSAs with HealthEquity? ☐ Yes ☐ No

HRA Plan Design (Please note, handwritten options or deviations from this form will not be accepted.) Group Number: _____

Plan Year Start Date | Plan Year End Date | Medical Deductible Plan Start Date | Medical Deductible Plan End Date

Plan Year Run-Out End Date: _____
Run-out is the date after the end of the plan year for HRA will continue to pay for expenses incurred during the plan year. Rollover funds are not available until run-out period is complete.

Plan Year Run-Out Days for Terminated Employees:
☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other ____ days ☐ or by plan year run-out date
Note: Run-out is the number of days after the end of the plan year the HRA will continue to pay for expenses incurred during the plan year. Rollover funds are not available until run-out period is complete. HRA will pay expenses for terminated employees that were incurred on or before the termination date, if received within this number of days following termination.

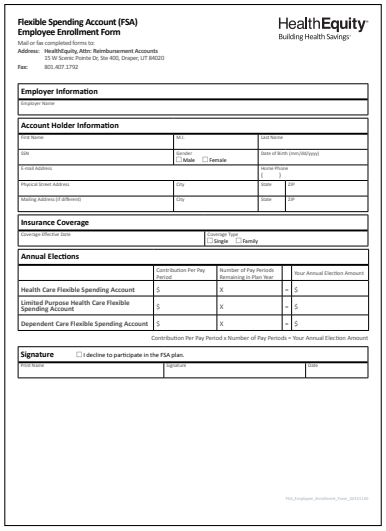
HRA Type – Select one and complete the corresponding section below.

☐ HRA Pays First ☐ Employee Pays First ☐ Bridge—HRA pays, then Employee pays, then HRA pays ☐ HRA with Debit Card

HealthEquity, Inc. is an independent company supporting Blue Cross Blue Shield of Michigan by providing health care spending account administration services.

Title: Employer Application for HRAs and FSAs

Description: Used to apply for an HRA or FSA and select account features


Flexible Spending Account (FSA) Employee Enrollment Form

HealthEquity Building Health Savings

Mail or fax completed forms to:
Address: HealthEquity, Attn: Reimbursement Accounts
15 W Scenic Pointe Dr, Ste 400, Draper, UT 84020
Fax: 801.407.1792

Employer Information

Employer Name

Account Holder Information

First Name | M.I. | Last Name
SSN | Gender ☐ Male ☐ Female | Date of Birth (mm/dd/yyyy)
E-mail Address | Home Phone ( )
Physical Street Address | City | State | ZIP
Mailing Address (if different) | City | State | ZIP

Insurance Coverage

Coverage Effective Date | Coverage Type ☐ Single ☐ Family

Annual Elections

	Contribution Per Pay Period		Number of Pay Periods Remaining in Plan Year		Your Annual Election Amount
Health Care Flexible Spending Account	$	X		=	$
Limited Purpose Health Care Flexible Spending Account	$	X		=	$
Dependent Care Flexible Spending Account	$	X		=	$

Contribution Per Pay Period x Number of Pay Periods = Your Annual Election Amount

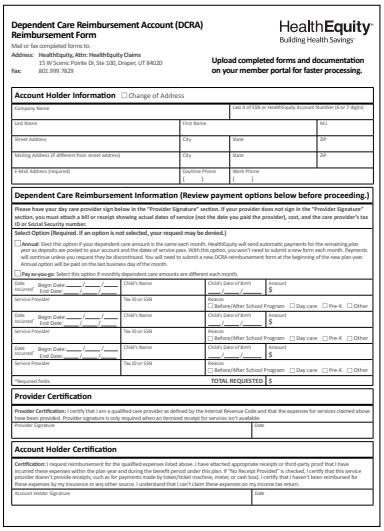
Signature ☐ I decline to participate in the FSA plan.

Print Name | Signature | Date

Title: Flexible Spending Account (FSA) Employee Enrollment Form

Description: Used to enroll employees into an FSA

EMPLOYEE


Dependent Care Reimbursement Account (DCRA) Reimbursement Form

HealthEquity Building Health Savings

Mail or fax completed forms to:
Address: HealthEquity, Attn: HealthEquity Claims
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020
Fax: 801.999.7829

Upload completed forms and documentation on your member portal for faster processing.

Account Holder Information ☐ Change of Address

Company Name | Last 4 of SSN or HealthEquity Account Number (6 or 7 digits)
Last Name | First Name | M.I.
Street Address | City | State | ZIP
Mailing Address (if different from street address) | City | State | ZIP
E-Mail Address (required) | Daytime Phone ( ) | Work Phone ( )

Dependent Care Reimbursement Information (Review payment options below before proceeding.)

Please have your day care provider sign below in the "Provider Signature" section. If your provider does not sign in the "Provider Signature" section, you must attach a bill or receipt showing actual dates of service (not the date you paid the provider), cost, and the care provider's tax ID or Social Security number.

Select Option (Required. If an option is not selected, your request may be declined.)

☐ Annual: Elect this option if your dependent care amount is the same each month. HealthEquity will send automatic payments for the remaining plan year as deposits are posted to your account and the dates of service pass. With this option, you won't need to submit a new form each month. Payments will continue unless you request they be discontinued. You will need to submit a new DCRA reimbursement form at the beginning of the new plan year. Annual option will be paid on the last business day of the month.

☐ Pay-as-you-go: Select this option if monthly dependent care amounts are different each month.

Date Incurred: Begin Date: ___/___/___ End Date: ___/___/___ | Child's Name | Child's Date of Birth ___/___/___ | Amount $
Service Provider | Tax ID or SSN | Reason ☐ Before/After School Program ☐ Day care ☐ Pre-K ☐ Other
(repeated)

*Required fields. TOTAL REQUESTED $

Provider Certification

Provider Certification: I certify that I am a qualified care provider as defined by the Internal Revenue Code and that the expenses for services claimed above have been provided. Provider signature is only required when an itemized receipt for services isn't available.

Provider Signature | Date

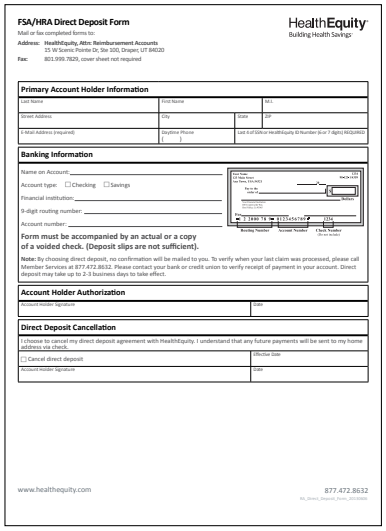
Account Holder Certification

Certification: I request reimbursement for the qualified expenses listed above. I have attached appropriate receipts or third-party proof that I have incurred these expenses within the plan year and during the benefit period under this plan. If "No Receipt Provided" is checked, I certify that this service provider doesn't provide receipts, such as for payments made by token/ticket machine, meter, or cash box). I certify that I haven't been reimbursed for these expenses by my insurance or any other source. I understand that I can't claim these expenses on my income tax return.

Account Holder Signature | Date

Title: Dependent Care Reimbursement Account (DCRA) Reimbursement Form

Description: Used to request reimbursement for qualified medical expenses


FSA/HRA Direct Deposit Form

HealthEquity Building Health Savings

Mail or fax completed forms to:
Address: HealthEquity, Attn: Reimbursement Accounts
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020
Fax: 801.999.7829, cover sheet not required

Primary Account Holder Information

Last Name | First Name | M.I.
Street Address | City | State | ZIP
E-Mail Address (required) | Daytime Phone ( ) | Last 4 of SSN or HealthEquity ID Number (6 or 7 digits) REQUIRED

Banking Information

Name on Account: _____
Account type: ☐ Checking ☐ Savings
Financial institution: _____
9-digit routing number: _____
Account number: _____

Routing Number | Account Number | Check Number

Form must be accompanied by an actual or a copy of a voided check. (Deposit slips are not sufficient).

Note: By choosing direct deposit, no confirmation will be mailed to you. To verify when your last claim was processed, please call Member Services at 877.472.8632. Please contact your bank or credit union to verify receipt of payment in your account. Direct deposit may take up to 2-3 business days to take effect.

Account Holder Authorization

Account Holder Signature | Date

Direct Deposit Cancellation

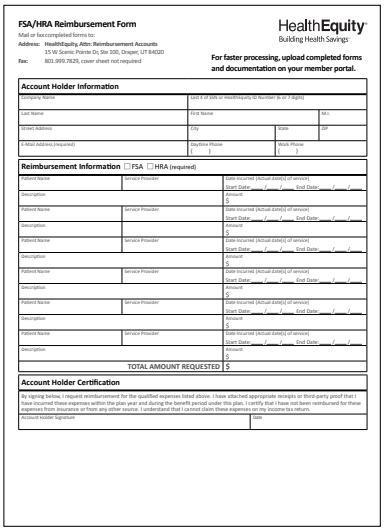
I choose to cancel my direct deposit agreement with HealthEquity. I understand that any future payments will be sent to my home address via check.

☐ Cancel direct deposit | Effective Date
Account Holder Signature | Date

www.healthequity.com 877.472.8632

Title: FSA/HRA Direct Deposit Form

Description: Used to set up direct deposit


FSA/HRA Reimbursement Form

HealthEquity Building Health Savings

Mail or fax completed forms to:
Address: HealthEquity, Attn: Reimbursement Accounts
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020
Fax: 801.999.7829, cover sheet not required

For faster processing, upload completed forms and documentation on your member portal.

Account Holder Information

Company Name | Last 4 of SSN or HealthEquity ID Number (6 or 7 digits)
Last Name | First Name | M.I.
Street Address | City | State | ZIP
E-Mail Address (required) | Daytime Phone ( ) | Work Phone ( )

Reimbursement Information ☐ FSA ☐ HRA (required)

Patient Name | Service Provider | Date Incurred (Actual date(s) of service) Start Date ___/___/___ End Date ___/___/___ | Description | Amount $
(repeated)

TOTAL AMOUNT REQUESTED $

Account Holder Certification

By signing below, I request reimbursement for the qualified expenses listed above. I have attached appropriate receipts or third-party proof that I have incurred these expenses within the plan year and during the benefit period under this plan. I certify that I have not been reimbursed for these expenses from insurance or from any other source. I understand that I cannot claim these expenses on my income tax return.

Account Holder Signature | Date

Title: FSA/HRA Reimbursement Form

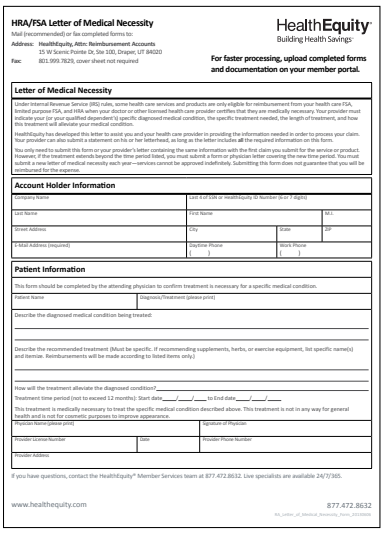
Description: Used to request reimbursement for qualified medical expenses

Forms

Documents in this section are developed by HealthEquity. Contact your account manager if you need copies.

HRA/FSA

EMPLOYEE



HRA/FSA Letter of Medical Necessity

Mail (recommended) or fax completed forms to:

Address: HealthEquity, Attn: Reimbursement Accounts
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020

Fax: 801.999.7829, cover sheet not required

HealthEquity
Building Health Savings

For faster processing, upload completed forms and documentation on your member portal.

Letter of Medical Necessity

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your health care FSA, limited purpose FSA, and HRA when your doctor or other licensed health care provider certifies that they are medically necessary. Your provider must indicate your (or your qualified dependent's) specific diagnosed medical condition, the specific treatment needed, the length of treatment, and how this treatment will alleviate your medical condition.

HealthEquity has developed this letter to assist you and your health care provider in providing the information needed in order to process your claim. Your provider can also submit a statement on his or her letterhead, as long as the letter includes all the required information on this form.

You only need to submit this form or your provider's letter containing the same information with the first claim you submit for the service or product. However, if the treatment extends beyond the time period listed, you must submit a form or physician letter covering the new time period. You must submit a new letter of medical necessity each year—services cannot be approved indefinitely. Submitting this form does not guarantee that you will be reimbursed for the expense.

Account Holder Information

Company Name | Last 4 of SSN or HealthEquity ID Number (6 or 7 digits)

Last Name | First Name | M.I.

Street Address | City | State | ZIP

E-Mail Address (required) | Daytime Phone ( ) | Work Phone ( )

Patient Information

This form should be completed by the attending physician to confirm treatment is necessary for a specific medical condition.

Patient Name | Diagnosis/Treatment (please print)

Describe the diagnosed medical condition being treated:

Describe the recommended treatment (Must be specific. If recommending supplements, herbs, or exercise equipment, list specific name(s) and itemize. Reimbursements will be made according to listed items only.)

How will the treatment alleviate the diagnosed condition?

Treatment time period (not to exceed 12 months): Start date ___/___/___ to End date ___/___/___

This treatment is medically necessary to treat the specific medical condition described above. This treatment is not in any way for general health and is not for cosmetic purposes to improve appearance.

Physician Name (please print) | Signature of Physician

Provider License Number | Date | Provider Phone Number

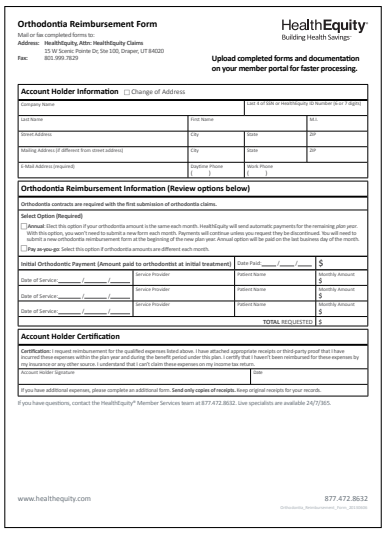
Provider Address

If you have questions, contact the HealthEquity® Member Services team at 877.472.8632. Live specialists are available 24/7/365.

www.healthequity.com 877.472.8632

Title: HRA/FSA Letter of Medical Necessity

Description: Used to substantiate purchases made with HRA/FSA funds



Orthodontia Reimbursement Form

Mail or fax completed forms to:

Address: HealthEquity, Attn: HealthEquity Claims
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020

Fax: 801.999.7829

HealthEquity
Building Health Savings

Upload completed forms and documentation on your member portal for faster processing.

Account Holder Information ☐ Change of Address

Company Name | Last 4 of SSN or HealthEquity ID Number (6 or 7 digits)

Last Name | First Name | M.I.

Street Address | City | State | ZIP

Mailing Address (if different from street address) | City | State | ZIP

E-Mail Address (required) | Daytime Phone ( ) | Work Phone ( )

Orthodontia Reimbursement Information (Review options below)

Orthodontia contracts are required with the first submission of orthodontia claims.

Select Option (Required)

☐ **Annual**: Elect this option if your orthodontia amount is the same each month. HealthEquity will send automatic payments for the remaining plan year. With this option, you won't need to submit a new form each month. Payments will continue unless you request they be discontinued. You will need to submit a new orthodontia reimbursement form at the beginning of the new plan year. Annual option will be paid on the last business day of the month.

☐ **Pay-as-you-go**: Select this option if orthodontia amounts are different each month.

Initial Orthodontic Payment (Amount paid to orthodontist at initial treatment) | Date Paid: ___/___/___ | $

Date of Service: ___/___/___ | Service Provider | Patient Name | Monthly Amount $

Date of Service: ___/___/___ | Service Provider | Patient Name | Monthly Amount $

Date of Service: ___/___/___ | Service Provider | Patient Name | Monthly Amount $

TOTAL REQUESTED $

Account Holder Certification

Certification: I request reimbursement for the qualified expenses listed above. I have attached appropriate receipts or third-party proof that I have incurred these expenses within the plan year and during the benefit period under this plan. I certify that I haven't been reimbursed for these expenses by my insurance or any other source. I understand that I can't claim these expenses on my income tax return.

Account Holder Signature | Date

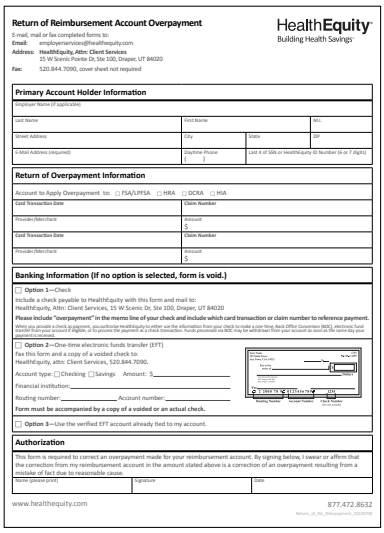
If you have additional expenses, please complete an additional form. **Send only copies of receipts.** Keep original receipts for your records.

If you have questions, contact the HealthEquity® Member Services team at 877.472.8632. Live specialists are available 24/7/365.

www.healthequity.com 877.472.8632

Title: Orthodontia Reimbursement Form

Description: Used to request reimbursement for eligible orthodontia expenses



Return of Reimbursement Account Overpayment

E-mail, mail or fax completed forms to:

Email: employerservices@healthequity.com

Address: HealthEquity, Attn: Client Services
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020

Fax: 520.844.7090, cover sheet not required

HealthEquity
Building Health Savings

Primary Account Holder Information

Employer Name (if applicable)

Last Name | First Name | M.I.

Street Address | City | State | ZIP

E-Mail Address (required) | Daytime Phone ( ) | Last 4 of SSN or HealthEquity ID Number (6 or 7 digits)

Return of Overpayment Information

Account to Apply Overpayment to: ☐ FSA/LPFSA ☐ HRA ☐ DCRA ☐ HIA

Card Transaction Date | Claim Number

Provider/Merchant | Amount $

Card Transaction Date | Claim Number

Provider/Merchant | Amount $

Banking Information (If no option is selected, form is void.)

☐ **Option 1**—Check

Include a check payable to HealthEquity with this form and mail to:
HealthEquity, Attn: Client Services, 15 W Scenic Dr, Ste 100, Draper, UT 84020

Please include "overpayment" in the memo line of your check and include which card transaction or claim number to reference payment.

When you provide a check as payment, you authorize HealthEquity to either use the information from your check to make a one-time, Back Office Conversion (BOC), electronic fund transfer (EFT) from your account or to process the payment as a check transaction. You're promised we may not withdraw funds from your account as soon as the same day your payment is received.

☐ **Option 2**—One-time electronic funds transfer (EFT)

Fax this form and a copy of a voided check to:
HealthEquity, attn: Client Services, 520.844.7090.

Account type: ☐ Checking ☐ Savings Amount: $

Financial institution:

Routing number: Account number:

Form must be accompanied by a copy of a voided or an actual check.

☐ **Option 3**—Use the verified EFT account already tied to my account.

Authorization

This form is required to correct an overpayment made for your reimbursement account. By signing below, I swear or affirm that the correction from my reimbursement account in the amount stated above is a correction of an overpayment resulting from a mistake of fact due to reasonable cause.

Name (please print) | Signature | Date

www.healthequity.com 877.472.8632

Title: Return of Reimbursement Account Overpayment

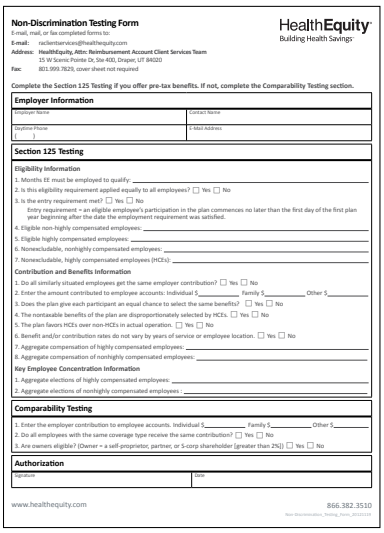
Description: Used to correct an account overpayment

Forms

Documents in this section are developed by HealthEquity. Contact your account manager if you need copies.

HSA/HRA/FSA

EMPLOYER



Non-Discrimination Testing Form

E-mail, mail, or fax completed forms to:

E-mail: raclientservices@healthequity.com

Address: HealthEquity, Attn: Reimbursement Account Client Services Team
15 W Scenic Pointe Dr, Ste 400, Draper, UT 84020

Fax: 801.999.7829, cover sheet not required

Complete the Section 125 Testing if you offer pre-tax benefits. If not, complete the Comparability Testing section.

Employer Information

Employer Name | Contact Name

Daytime Phone ( ) | E-Mail Address

Section 125 Testing

Eligibility Information

1. Months EE must be employed to qualify: _____
2. Is this eligibility requirement applied equally to all employees? ☐ Yes ☐ No
3. Is the entry requirement met? ☐ Yes ☐ No
   Entry requirement = an eligible employee's participation in the plan commences no later than the first day of the first plan year beginning after the date the employment requirement was satisfied.
4. Eligible non-highly compensated employees: _____
5. Eligible highly compensated employees: _____
6. Nonexcludable, nonhighly compensated employees: _____
7. Nonexcludable, highly compensated employees (HCEs): _____

Contribution and Benefits Information

1. Do all similarly situated employees get the same employer contribution? ☐ Yes ☐ No
2. Enter the amount contributed to employee accounts: Individual $_____ Family $_____ Other $_____
3. Does the plan give each participant an equal chance to select the same benefits? ☐ Yes ☐ No
4. The nontaxable benefits of the plan are disproportionately selected by HCEs. ☐ Yes ☐ No
5. The plan favors HCEs over non-HCEs in actual operation. ☐ Yes ☐ No
6. Benefit and/or contribution rates do not vary by years of service or employee location. ☐ Yes ☐ No
7. Aggregate compensation of highly compensated employees: _____
8. Aggregate compensation of nonhighly compensated employees: _____

Key Employee Concentration Information

1. Aggregate elections of highly compensated employees: _____
2. Aggregate elections of nonhighly compensated employees : _____

Comparability Testing

1. Enter the employer contribution to employee accounts. Individual $_____ Family $_____ Other $_____
2. Do all employees with the same coverage type receive the same contribution? ☐ Yes ☐ No
3. Are owners eligible? (Owner = a self-proprietor, partner, or S-corp shareholder [greater than 2%]) ☐ Yes ☐ No

Authorization

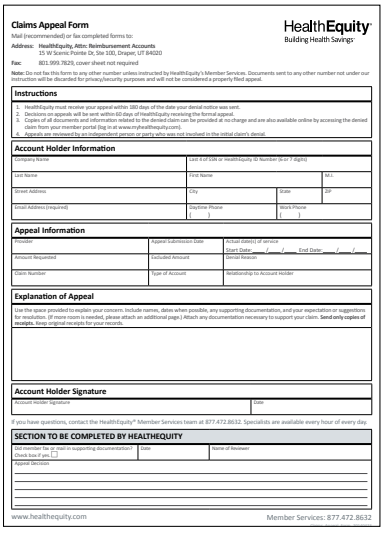
Signature | Date

www.healthequity.com 866.382.3510

Title: Non-Discrimination Testing Form

Description: Used to dispense non-discrimination testing to members

EMPLOYEE



Claims Appeal Form

Mail (recommended) or fax completed forms to:

Address: HealthEquity, Attn: Reimbursement Accounts
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020

Fax: 801.999.7829, cover sheet not required

Note: Do not fax this form to any other number unless instructed by HealthEquity's Member Services. Documents sent to any other number not under our instruction will be discarded for privacy/security purposes and will not be considered a properly filed appeal.

Instructions

1. HealthEquity must receive your appeal within 180 days of the date your dental notice was sent.
2. Decisions on appeals will be sent within 60 days of HealthEquity receiving the formal appeal.
3. Copies of all documents and information related to the denied claim can be provided at no charge and are also available online by accessing the denied claim from your member portal (log in at www.myhealthequity.com).
4. Appeals are reviewed by an independent person or party who was not involved in the initial claim's denial.

Account Holder Information

Member's Name | Last 4 of SSN or HealthEquity ID Number (6 or 7 digits)

Last Name | First Name | M.I.

Street Address | City | State | ZIP

Email Address (required) | Daytime Phone ( ) | Work Phone ( )

Appeal Information

Provider | Appeal Submission Date | Actual date(s) of service Start Date: __/__/__ End Date: __/__/__

Amount Requested | Excluded Amount | Denial Reason

Claim Number | Type of Account | Relationship to Account Holder

Explanation of Appeal

Use the space provided to explain your concern. Include names, dates when possible, any supporting documentation, and your expectation or suggestions for resolution. (If more room is needed, please attach an additional page.) Attach any documentation necessary to support your claim. **Send only copies of receipts.** Keep original receipts for your records.

Account Holder Signature

Account Holder Signature | Date

If you have questions, contact the HealthEquity® Member Services team at 877.472.8632. Specialists are available every hour of every day.

SECTION TO BE COMPLETED BY HEALTHEQUITY

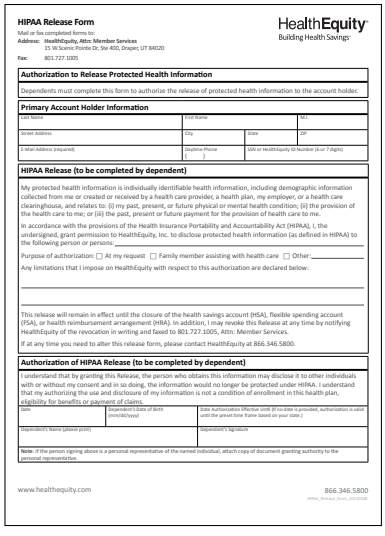
Did member fax or mail in supporting documentation? Check box if yes ☐ | Date | Name of Reviewer

Appeal Decision

www.healthequity.com Member Services: 877.472.8632

Title: Claims Appeal Form

Description: Used to appeal the denial of a claim



HIPAA Release Form

Mail or fax completed forms to:

Address: HealthEquity, Attn: Member Services
15 W Scenic Pointe Dr, Ste 400, Draper, UT 84020

Fax: 801.727.1005

Authorization to Release Protected Health Information

Dependents must complete this form to authorize the release of protected health information to the account holder.

Primary Account Holder Information

Last Name | First Name | M.I.

Street Address | City | State | ZIP

E-Mail Address (required) | Daytime Phone ( ) | SSN or HealthEquity ID Number (6 or 7 digits)

HIPAA Release (to be completed by dependent)

My protected health information is individually identifiable health information, including demographic information collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse, and relates to: (i) my past, present, or future physical or mental health condition; (ii) the provision of the health care to me; or (iii) the past, present or future payment for the provision of health care to me.

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA), I, the undersigned, grant permission to HealthEquity, Inc. to disclose protected health information (as defined in HIPAA) to the following person or persons: _____

Purpose of authorization: ☐ At my request ☐ Family member assisting with health care ☐ Other: _____

Any limitations that I impose on HealthEquity with respect to this authorization are declared below:

This release will remain in effect until the closure of the health savings account (HSA), flexible spending account (FSA), or health reimbursement arrangement (HRA). In addition, I may revoke this Release at any time by notifying HealthEquity of the revocation in writing and faxed to 801.727.1005, Attn: Member Services.

If at any time you need to alter this release form, please contact HealthEquity at 866.346.5800.

Authorization of HIPAA Release (to be completed by dependent)

I understand that by granting this Release, the person who obtains this information may disclose it to other individuals with or without my consent and in so doing, the information would no longer be protected under HIPAA. I understand that my authorizing the use and disclosure of my information is not a condition of enrollment in this health plan, eligibility for benefits or payment of claims.

Date | Dependent's Date of Birth (mm/dd/yyyy) | Date Authorization Effective Until (if no date is provided, authorization is valid until the preset time frame based on your state.)

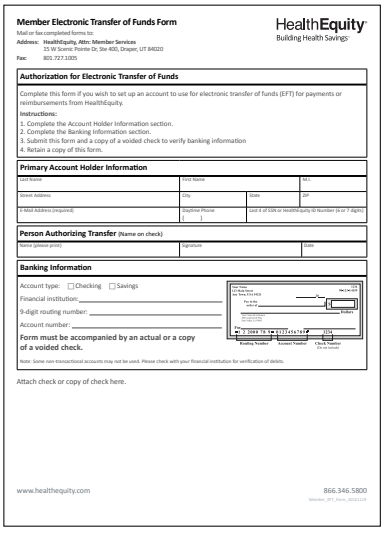
Dependent's Name (please print) | Dependent's Signature

Note: If the person signing above is a personal representative of the named individual, attach copy of document granting authority to the personal representative.

www.healthequity.com 866.346.5800

Title: HIPAA Release Form

Description: Used to authorize the release of a dependent's protected health information to the account holder



Member Electronic Transfer of Funds Form

Mail or fax completed forms to:

Address: HealthEquity, Attn: Member Services
15 W Scenic Pointe Dr, Ste 400, Draper, UT 84020

Fax: 801.727.1005

Authorization for Electronic Transfer of Funds

Complete this form if you wish to set up an account to use for electronic transfer of funds (EFT) for payments or reimbursements from HealthEquity.

Instructions:

1. Complete the Account Holder Information section.
2. Complete the Banking Information section.
3. Submit this form and a copy of a voided check to verify banking information
4. Retain a copy of this form.

Primary Account Holder Information

Last Name | First Name | M.I.

Street Address | City | State | ZIP

E-Mail Address (required) | Daytime Phone ( ) | Last 4 of SSN or HealthEquity ID Number (6 or 7 digits)

Person Authorizing Transfer (Name on check)

Name (please print) | Signature | Date

Banking Information

Account type: ☐ Checking ☐ Savings

Financial institution: _____

9-digit routing number: _____

Account number: _____

Form must be accompanied by an actual or a copy of a voided check.

Note: Some non-transactional accounts may not be used. Please check with your financial institution for verification of debits.

Attach check or copy of check here.

www.healthequity.com 866.346.5800

Title: Member Electronic Funds Transfer Form

Description: Used to set up electronic transfer of funds for payments or reimbursements from HealthEquity

bcbsm.com