Coverage Level Update Form

Complete and remit this form if requesting to update your High Deductible Health Plan (HDHP) coverage level associated with your Health Savings Account.

Step 1: Accountholder Information

*=Required Fields

*Employer Name

Employee ID

*Accountholder Name (First, MI, Last)

*Social Security Number ___ - __ - ____

*Permanent Address

*City

*State

*Zip

Step 2: HDHP Coverage Level

* Please Select One:

Single **Family**

* Effective Date

Step 3: Consumer Authorization

You acknowledge that the changes specified on this form shall become effective as soon as administratively feasible upon the receipt and acceptance of this form by HSA Bank.

* Accountholder Signature

Date

Mail or fax signed form and supporting documentation to:

HSA Bank
P.O. Box 939
Sheboygan, WI 53082

Fax: (877) 851-7041
Please call HSA Bank at (855) 731-5213 with any questions.