

American Benefit Services, LLC
Employer Information Sheet
Health Savings Accounts

Legal Name of Company: _____

Federal Tax Id#: _____

Contact Person: _____ Title: _____

Street Address: _____

City: _____ State/Zip _____

Phone: _____

Fax: _____ Email: _____

HSA Contribution Information:

_____ I will be contributing to my Employee's Accounts
\$ _____ Lump Sum Contribution
\$ _____ Per Pay / Month Contribution

_____ I will not be contributing to my Employee's Accounts

_____ I will send a check to ABS Monthly / Weekly / Bi-weekly for my employee's contributions

_____ I would like ABS to draft my account Monthly / Weekly / Bi-weekly for my employee's contributions (Please attach ACH Authorization Form)

_____ I need ABS to create a Premium Conversion Plan (Section 125) for my company

Employer Signature

Date

Employer Printed Name

