HSA Enrollment Form

Allegiance℠ by Cigna Healthcare

Instructions

1. Complete this form to enroll in an Allegiance Advantage HSA.
2. Securely email, mail, or fax completed form to:
   Secure Email: allegianceform@healthaccountservices.com
   Address: P.O. Box 2396 Fargo, ND 58108-2396
   Fax: (833) 480-7005
3. Login to your account on the HSA website to review and accept the Terms and Conditions governing the account.
4. **Contributions can be submitted via the consumer portal or HSA Contribution Form after you receive a confirmation of your HSA enrollment.**
5. Verification of your identity is required for opening an HSA and may result in needing to supply additional information. If this applies to you, then you will be notified by Allegiance Advantage on how to proceed.
6. If you have any questions about completing this form, please contact Allegiance Advantage Consumer Services at (877)424-3570. We have representatives available Monday-Friday, 7:00 am to 7:00 pm CST.

Step 1: Consumer Information
*Required Fields

*Consumer Name (First, MI, Last)

*Email Address

*Birth Date (MM/DD/YYYY) / /

*Social Security Number - -

*Home Phone ( ) -

*Permanent Address

Mobile Phone ( ) -

*City

*State

*Zip Code

Step 2: Election

*Indicate HDHP Coverage Level ☐ Single ☐ Family

*Effective Date

Step 3: Authorization and Eligibility Election

When opening an HSA with Allegiance Advantage, I understand and agree to the following:

- **I am at least 18 years old and cannot be claimed as a dependent on someone else's tax return.**
- **I am covered under a high deductible health plan (HDHP).**
- **I am not enrolled in Medicare.**
- **I do not have any other non-qualified health coverage.**
- **I do not have a flexible spending account (FSA) to pay for medical expenses incurred before my medical plan deductible is met, unless it is limited to pay for dental and vision expenses only.**
- **My spouse, if applicable, does not have a flexible spending account (FSA) to pay for medical expenses before their medical plan deductible is met, unless it is limited to pay for dental and vision expenses only.**

By executing this form, I acknowledge that I am required to login to the HSA website to review and accept the terms and conditions governing the account. I agree to receive future notices of any updates at the HSA website or at www.wexinc.com/wb/wex-custodian-services, and to review no less frequently than annually. As a follow-up to this application, you may need to login to the HSA website to review and accept further account disclosures and to also view your interest schedule and fee schedule, if applicable.

*Consumer Signature

*Date