Employer Invoicing/Funding Form

hsabank A Division of Webster Bank, N.A., Member FDIC for cigna healthcare

Instructions: Complete this form to update your invoicing preferences, daily limit for Group Online Contribution, or banking information for fees and/or funding.
Please complete and return this form to your Cigna Healthcare Consumer Account Specialist.

This form must be signed by an authorized agent of the employer. The authorized agent must be an active contact on file with HSA Bank.

COMPANY INFORMATION ON FILE WITH HSA BANK: (All Fields Required)		
Company Name:	Employer Federal Tax ID Number:	Employer Code: **(For Bank Use Only)**:

PART 1 – HSA FEES: MONTHLY SERVICE FEE (This section is used to enable/disable invoicing.)

☐ Invoice to Employer*:
☐ Charge to Employee:

*Banking information is Required.

Terms of the final negotiated contract, if applicable, would govern.

Please fill out the Financial Institution Information below and complete the Authorization Agreement for Direct Payment (page 2 of 2).

PART 2 – UPDATE DAILY LIMIT**
(If you are enrolled in Group Online Contribution [GOC], use this section to update your daily limit.)

Requested Daily Limit Amount:	Number of Employees:

***All daily contribution limits are subject to HSA Bank's approval.*

PART 3 – FINANCIAL INSTITUTION INFORMATION
(Use this section to add or update your bank account. This section is also required if you enabled invoicing in Part 1.)

Please be sure to inform your external bank to allow debits from HSA Bank (ACH Company ID# 1390634250). Please also complete the Authorization Agreement for Direct Payment (page 2 of 2) if invoicing is being added or updated.

Financial Institution Name:	Bank Contact:	Phone:
ACH Routing Number:	Account Number:	☐ Checking ☐ Savings

USE THIS BANK ACCOUNT FOR:

☐ Add Invoice Account
☐ Update Invoicing Account
☐ Update GOC Funding Account

HSA Bank shall not be liable to the employee for any losses, damages, costs, penalties, or expenses incurred as a result of the employer's failure to make the contributions to the employee's HSA or failure to repay HSA Bank for any HRA/FSA claims (if this occurs, we may cease administration for claims for employees) required under the employer's health plan. HSA Bank is not responsible for monitoring the employer contributions to the employee's HSA or notifying the employee of the employer's contributions. The employee is responsible for contacting the employer regarding contributions and monitoring those contributions. HSA Bank provides periodic statements to the employee.

Your signature below certifies the information provided on this form is accurate.

AUTHORIZATION:

Name:	Title:
Signature:	Date:

BANK USE ONLY:

CIP/COMP Date:	Processor:	Approved Limit:
Authorized Signer:	Date:	Daily Limit:

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

I hereby authorize HSA Bank, hereinafter called BANK to initiate debit entries to COMPANY's

☐ Checking Account/ ☐ Savings Account (select one) on file with BANK or indicated in Part 4 of this form, hereinafter called DEPOSITORY, and to debit the same to such account for payment of the monthly invoiced Health Savings Account service fees for our employees. An email notification will be sent to you with online access to your invoice at least 8 days in advance of your monthly, scheduled payment dates. Your monthly invoices and employee list will be available online at the Employer Administration Site. I acknowledge that the origination of ACH transactions to COMPANY's account must comply with the provisions of U.S. law.

This authorization is to remain in full force and effect until BANK has received written notification from COMPANY of its termination in such time and in such manner as to afford BANK and DEPOSITORY a reasonable opportunity to act on it. **I certify that I am the authorized signer on the account for COMPANY**.

Name(s): (Please Print)

Signature:	Date:

NOTE: COMPANY termination or changes to this authorization for debit entries for monthly HSA service fee invoiced payments can be done by contacting HSA Bank via phone, secure email or U.S. mail. HSA Bank may terminate this authorization or the option to allow the COMPANY to be invoiced for their employees' Health Savings Account service fees upon 30 days notification to the COMPANY. Upon HSA Bank termination, COMPANY'S employees may be charged HSA Bank monthly Health Savings Account service fees by direct debit to the employees' Health Savings Accounts. If cause for termination is due to non-payment of service fees by COMPANY after reasonable attempts to collect have been performed, HSA Bank may terminate this agreement immediately without notification to the COMPANY.