CareFirst

HEALTH SAVINGS ACCOUNT CONTRIBUTION FORM

Account Holder's Name and Address	Spending Account ID #
Last Name _____ First Name _____ Middle Initial _____ Street Address _____ City _____ State _____ Zip _____ Email address _____	S A _ _ _ _ _ _ _ _ **Social Security #** (if SA# is not known) **Daytime Phone**

Contributions

Account Type: ☐ HSA ☐ MSA

☐ I wish to make a single contribution by **check** (Please make checks payable to Further).

Amount: $_____

Tax Year: _____

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment, and you will not receive your check back from your financial institution.

☐ I wish to authorize **an electronic funds transfer:**

- ☐ Please initiate a one-time pull from the account I have indicated on the reverse side of this form.
- ☐ Please initiate a one-time pull from the existing bank account on file at Further, bank account number: _____

  Amount: $_____

  Tax Year: _____
- ☐ Please initiate an ongoing monthly draft from the account I have indicated on the reverse side of this form.
- ☐ Please initiate an ongoing monthly draft from the existing bank account on file at Further, bank account number: _____

  I understand that funds will be drawn from my account on or around the 5th day of each month.

  Amount: $_____

  Tax Year will be the current year: _____

Signature

It is my responsibility (1) to determine whether I am eligible to make contributions to my HSA, and (2) to determine whether contributions to this HSA have exceeded the applicable maximum annual contribution limit. For current eligibility guidelines and contribution limits, go to CareFirst.com/MyAccount

I understand deposits might not be available for immediate withdrawal until confirmation by my financial institution.

_____ _____

Account Holder Date

Authorization for Electronic Transfer of Funds

As an added convenience, Further can automatically transfer contributions and/or distributions between your bank account and your health savings account. Once you have authorized Further to automatically transfer funds, there is no need to re-enroll in subsequent plan years unless there is a change in your bank information.

To begin the electronic transfer of funds or change bank account information, please complete the following:

The bank information I have provided is intended to be used as indicated below:

☐ Contribution(s) to Further **and/or** ☐ Withdrawal(s) from Further

☐ checking or ☐ savings account

Please note that we cannot transfer funds into investment accounts at this time.

Name of member (please print): _____

Spending Account or Social Security Number: _____

Employer's Name (if applicable): _____

Bank name: _____

Bank telephone number: _____

Bank ABA Routing Number: __ __ __ __ __ __ __ __ __

(The ABA routing number is the nine-digit number located in the bottom left corner of your check or deposit slip)

Bank Account Number: _____

_____ Signature Date: _____

Signature of Bank Account Holder

Please allow 10-15 business days from the date this form is received by Further for your request to be processed. You may receive a manual check if claims are processed before the direct deposit is effective.

Save time: submit this information online. Questions? Call Member Services at 1-866-758-6199.

Submit online:
Log into your account at CareFirst.com/MyAccount

Send via secured email only:
CareFirstDocuments@hellofurther.com

Fax to:
866-231-0214

Mail to:
Further c/o CareFirst
P.O. Box 64193
St. Paul, MN 55164-0193