DriveTime Benefits Department
Benefits@DriveTime.com
www.DriveTimeBenefts.com
Fax: 866-665-7197

Health Savings Account Enrollment/Change Form

Name: _____

Employee ID: _____

Date of Enrollment/Change: _____

By Requesting a Health Savings Account you acknowledge your authorization to open your savings account and for withdrawals or other transactions to your account. Your signature confirms that you are agreeing to the terms of the Affirmation Points posted on the Benefits Website: www.DriveTimeBenefits.com.

Employee Signature: _____

Health Savings Account (Liberty Plan Only):

☐ Savings Account*
Plan Year Goal Amount $_____
(minimum $100, max $3100 for employee only, max $6250 for employee+ coverage)

*DriveTime will match your contribution up to:

$250 for employee only coverage

$500 for employee + coverage