PSF Intake Form

HealthEquity®

Business Information

Company Name		Tax ID
Primary Contact	Email	Phone Number
Street Address	City	State / ZIP

☐ I acknowledge that I am the authorized client contact.

Integrated File Request Information

1. **What product/plan are you requesting a file for?**

   ☐ Commuter (If you offer the Commuter Order Model plan there is no enrollment option. Enrollment is done individually by the member. The file captures benefit eligibility information only.)

   ☐ ESPL (e.g., Fitness, Wellness, Gym, Bike Reimbursements)

   ☐ FSA (includes Health Care, Dependent Care FSA)

   ☐ Limited Purpose FSA

   ☐ HRA

   ☐ HSA

   Expected file production date _____

2. **If HSA is offered, how many active HSA accounts will you have on the file? (Not Benefit Eligible, but Active Accounts)**

3. **What kind of file are you requesting?**

   ☐ Eligibility (demographic information about the member)

   ☐ Enrollment (identifies the plans that members are enrolled in)

   ☐ Funding (reports employee or employer contributions)

   What do you want the files for? _____

4. **Do you currently have any files established with HealthEquity?**

   ☐ Yes   ☐ No (If you answered 'No' on Question 6, please skip Questions 5, 6 and 7.)

5. **What kind of files are currently sent?**

   ☐ Eligibility (demographic information about the member)

   ☐ Enrollment (identifies the plans that members are enrolled in)

   ☐ Funding (reports employee or employer contributions)

6. **Who is your current file partner/vendor? (for example, ADP, Paycom, UKG, BenefitFocus, Workday, etc.)**

7. **Is the request to make changes to a current file or are you changing data vendors?**

   ☐ Yes   ☐ No

8. **Who is your new file partner/vendor? (for example, ADP, Paycom, UKG, BenefitFocus, Workday, etc.)**

9. **Who is your technical contact for the Vendor?** *You must have established a technical resource in order to proceed with this process.* **If not, please acquire a technical contact from your data vendor and then return to complete this form.**

Name of **enrollment** file technical resource	Email	Phone Number
Name of **funding** file technical resource	Email	Phone Number

10. **HealthEquity does not have fees associated with creating these files, but your data vendor may. Check 'Yes' below to confirm that you understand that costs associated with creating the file or making future changes/corrections to the file may be assessed by your data partner/vendor.**

    ☐ Yes, I understand

11. **Files take 60-90 days to complete, CLICK YES BELOW to acknowledge that you'll be handling contributions or eligibility/enrollments (including, if applicable, for Open Enrollment) manually through the Employer Portal until the file is completed.**

    ☐ Yes, I understand

Comments or Additional Notes: