



Health Net®
A BETTER DECISION

EMPLOYER ACKNOWLEDGEMENT FORM

Application Date: _____

Employer Name: _____

Employer Group Number (if applicable): _____

I understand that the Health Net HSA-Compatible or other high-deductible employer group plan I have selected is to be used as a stand-alone plan or in conjunction with a Health Savings Account (HSA) banking arrangement, where applicable.

I also understand that these plans are not to be combined with any form of partial self-funding or otherwise insuring of the deductible, whether in a wraparound, addition or companion capacity, including a partially self-funded Section 105 wraparound, now or in the future.

Signature of Company Officer

Please print name

Title

Date