

HSA Application

Complete electronically (optional).

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1 Personal Information.

Name _____ Soc. Sec. _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Employer _____ Occupation _____

E-mail _____ Driver's License _____ (attach copy- **required**) State Issued _____

Mother's Maiden Name _____ Birthplace _____ Agent/Broker _____

2 Contribution Information.

(Employer Plans: Do not complete this section if your HSA contributions are coming directly from your employer.)

Make check payable to Financial Institution above.
Initial Contribution: \$ _____
(If applicable): \$ _____
Other: \$ _____
Total: \$ _____

A. Type Regular Rollover Transfer (complete Transfer Form)

B. Tax Year: Current Year or Prior Year

C. Automated Contributions: If you want to set up monthly contributions to your HSA from your checking account, complete the following. You must attach a check from the account you would like to withdraw from.

Amount \$ _____ on the _____ of each month 15th or 30th

3 Signatures.

I have read and agree to the terms in the Custodial Agreement and Disclosure Statement and I agree that those terms and conditions apply to this HSA and that I am bound to those terms and conditions. If applicable, I hereby designate the beneficiaries of this HSA as those named on the second page of this Application in the HSA Designation of Beneficiaries section. If applicable, I hereby authorize the person named on the second page in the Authorized Signer section as authorized signer for this HSA. I understand that I am solely responsible to determine my eligibility to make this HSA contribution and to determine the tax deductibility of the contribution; including an understanding that I must be covered under a "High Deductible Health Plan" for annual contribution eligibility. I agree that I will consult with my tax or legal advisor if I need advice. I acknowledge that the Custodian named above cannot and does not provide me with tax or legal advice. I am solely responsible for determining the tax consequences of all distributions. I acknowledge and agree that the Custodian may share limited information with my employer or insurance agents. I certify that the information provided by me on this application is accurate.

T.I.N./Backup Withholding. (Cross out item (3) if you are subject to backup withholding) Under penalties of perjury, I certify (1) that the number shown is my correct taxpayer ID number or social security number, (2) that I am a U.S. person (including U.S. resident alien), (3) and that I am not subject to backup withholding because (a) I am exempt from backup withholding or (b) because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends or (c) because the IRS has notified me that I am no longer subject to backup withholding. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

<input type="checkbox"/> Check here if you completed the second page of this application.
Page 1 (this page) – Required information to open an HSA.
Page 2 (next page) – Optional beneficiary and authorized signer information can be completed at any time.

HSA Owner Signature

Date

HSA Designation of Beneficiary Form

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(optional)

HSA Owner Name: _____

4 Designation of Beneficiary.

A. Primary Beneficiaries. In the event of my death, pay my HSA balance to the following primary beneficiaries according to the percentages indicated. If more than one primary beneficiary is designated and no percentages are indicated, the beneficiaries will be deemed to own equal share percentages in the HSA. If a primary beneficiary dies before me, his or her share shall be reallocated on a pro-rata basis to any remaining primary beneficiaries.

Name and Address	SSN	Relationship	Date of Birth	Percentage

B. Contingent Beneficiaries. If all of my primary beneficiaries die before me, pay my HSA balance to the following contingent beneficiaries according to the percentages indicated. If a contingent beneficiary dies before me, his or her share shall be reallocated on a pro-rata basis to any remaining contingent beneficiaries.

Name and Address	SSN	Relationship	Date of Birth	Percentage

C. Spousal Consent. Complete only if you name someone other than your spouse as a primary beneficiary. Consult your tax or legal advisor with questions regarding naming beneficiaries in community or marital property states.

Spouse's Signature

Date

Witness' Signature

Date

HSA Authorized Signer (Optional)

5 Authorized Signer. If you want your spouse or other party to have access to the HSA, please complete the following section with the authorized signer's information. The authorized signer must sign below.

Authorized Name _____ Soc. Sec. # _____ Date of Birth _____

Mailing Address _____ City _____ State _____ Zip _____

Driver's License _____ (attach copy) State Issued _____ Phone _____

Mother's Maiden Name _____ Employer _____ Employer Phone _____

Signature of Additional Signer (Authorized Signer)

Date

Page 1 (previous page) - Required information to open an HSA
Page 2 (this page) - Optional beneficiary and authorized signer information can be completed at any time.