HEALTH SAVINGS ACCOUNT APPLICATION AND ELIGIBILITY FORM

HSA BANK™
National Leader in Health Savings Accounts.
A Division of Webster Bank, N.A.

For Tracking Purposes: Complete all that apply.

Affiliation	Broker Dealer	AIN #	Code In.	Code Ong.	SVC	Software
		012335	C	C		

MGA	TPA	Marketing	Group Fed ID #

Internal Use:

Instructions: **All fields must be completed.** For assistance, call 800-357-6246.
Para un formulario en Español por favor contactar 866-357-6232).
Return this application with a check to:

HSA Bank™, P.O. Box 939, Sheboygan, WI 53082-0939

Make Check Payable to HSA Bank

A. Set-up Fee	$	25.00
B. Check Order *($12.75, if requested)*	$	
C. Initial Contribution	$	
D. Total Amount Enclosed	$	

Personal Information

Please fill in all boxes (MM DD YYYY) (IE: 01 01 2006)

Social Security # **Birth Date**

First Name **MI** **Last Name**

Street Address *(Required)*

PO Box **City**

State **Zip** **Preferred Mailing Method** ☐ Street Address ☐ PO Box

Home # **Bus. #**

Form of Identification

☐ Driver's License ☐ State ID ☐ Passport **ID#**

Email

If email address is provided, HSA Bank will send an email confirmation following account opening. All accounts will also receive a Welcome Kit by mail within 2 weeks of account opening.

Note: To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. What this means to you: When you open an account we will ask for your name, street address, date of birth and other information that will allow us to identify you. We may request a copy of your driver's license or other identifying documents. If your identity cannot be authenticated, or your application is incomplete, your account will be opened in a frozen status.

HSA Account Options

Please read Power of Attorney section for spousal or third party access to your HSA.

Purchases made with either the debit MasterCard® or HSA Bank checks will be reported by the Bank as "normal distributions" and should only be used for qualified medical expenses. I understand I am responsible for any IRS penalties. I understand that I should submit an HSA withdrawal form for any non-qualifying or non-medical transaction at a cost of $4.00 per occurrence. I understand the bank will issue me a check. I understand I must pay a monthly fee of $2.25 for this account. The fee is waived each month for accounts that maintain a balance greater than $3,000 during the entire month period.

☐ I would like to order 50 non-duplicate checks, including 10 deposit tickets, at a cost of $12.75. *(Indicate amount on part B of Instructions section above)*

☐ I would like 1 free debit MasterCard issued in my name for my account.

☐ I would like to be enrolled in internet banking. (Email address required above for this option)

☐ I am interested in receiving Investment information (Non FDIC Insured: Stocks, Bonds, and Mutual Fund Options)

Initial Contribution Source and Amount

☐ Accountholder and/or Third Party Deposit
Total "Above the Line" Deductions (after tax) **Amt. ($)** .

☐ Employer Contribution
Pre-tax Deduction **Amt. ($)** .

☐ Employee Pre-Tax through Section 125 Plan
Contact your employer to utilize this option **Amt. ($)** .

Total Initial Contribution Amount ***(Indicate amount on part C of Instructions section above)*** **($)** .

Type of Initial Deposit - *Please check one*

☐ Regular-Year of Contribution *(Required)*

☐ Rollover/Transfer
(Please attach transfer/rollover form)

Payroll Deductions *Contact your employer to utilize this option*

☐ Monthly **Amt. ($)** .

☐ Per Payroll

Employer Information *(For help, see your Insurance or Employer Representative.)*

Employer Name

Federal ID # *(Employer Only - Required)*

Employer Consent

My employer wishes to have access to my HSA Bank account information in order to facilitate direct deposit of employer contributions to my account. I, as named on this application, authorize my employer to obtain my account information for the sole purpose of facilitating direct contributions to my account. I hold harmless and indemnify the Bank against any claims against or losses Bank may suffer arising out of Bank reliance on this authorization and release Bank from all liability arising from such reliance. This authorization remains in full force and effect until Bank receives written notice of revocation and has had a reasonable time to act upon such notice.

☐ My employer is not authorized to facilitate deposits to my account.

Eligibility Requirements: REGULAR HSA

☐ Y ☐ N **Account holder certification-** I certify that: (1) I am, or effective _____ (*Effective Date of HDHP*) will be covered by a ☐ single or ☐ family qualified High Deductible Health Plan (HDHP), with a deductible of _____ (*Deductible of HDHP*), (2) I certify that I am not covered by a health plan, other than a HDHP, which provides any of the same benefits as the HDHP, (3) I am not enrolled in Medicare, and (4) I may not be claimed as a dependent on another person's tax return.

If you answered NO to the above, you are not eligible to establish a qualified HSA.

Your HSA account will be considered established for tax purposes as of your first date of eligibility under your HDHP, provided that you have signed and dated the application for your HSA on or before that date. If we receive the application after your first date of eligibility under your HDHP, your HSA account will be considered established as of the date you signed and dated this application. To receive tax favored treatment for distributions from your HSA account, any qualified medical expenses must be incurred after the date that your HSA account is established.

Authorized Signer / Power of Attorney (POA) *(Optional):*

Since regulations require that only one individual own a Health Savings Account, the Accountholder may want his/her spouse and/or another third party through power of attorney to write checks or use his/her debit card. I (accountholder) hereby designate the following individual as additional authorized signer on my Health Savings Account.

Spouse/Other First **MI** **Last**

Social Security # **Birth Date**

Street Address

PO Box **City**

State **Zip** **Home #**

Second Debit Card Option

☐ I would like a second FREE debit MasterCard® issued, for the POA listed above, for my account to be used for normal distributions only.

By requesting a POA on my account, I agree to the following: My POA may perform any and all acts that I may perform pursuant to my Account agreement with the Bank, including signing in my name, electronically or otherwise, agreements and orders relating to the Account or access to the Account; withdrawing funds from or transferring funds into or out of the Account, by any means acceptable to Bank, including Internet access; and depositing, cashing, and endorsing any instrument, order or other document for the payment of money to me. I agree that POA may access all records relating to the Account and may give instructions to Bank regarding the Account. I hold harmless and indemnify the Bank against any claims against or losses Bank may suffer arising out of Bank reliance on this appointment and release Bank from and liability arising from such reliance. This appointment remains in full force and effect until Bank receives written notice of revocation and has had a reasonable time to act upon such notice. NO PRESENT OR FUTURE OWNERSHIP OR RIGHT OF SURVIVORSHIP IS CONFERRED BY THIS DESIGNATION. THE AUTHORITY OF THE AGENT IS EXERCISABLE NOTWITHSTANDING THE SUBSEQUENT DISABILITY OR INCAPACITY OF ANY DEPOSITOR

Signatures *Important: Please read before signing.*

HSA Bank is hereby appointed to serve as custodian of my Health Savings Account. HSA Bank (Division of Webster Bank N.A.) and Webster Bank N.A. are the same FDIC-insured institution. Deposits held under each trade name are not separately insured, but are combined to determine whether a depositor has exceeded the $100,000 federal deposit insurance limit. I have received a copy of and agree to the HSA Custodial Agreement, Privacy Policy, and Terms of Account (Account Disclosures). Within seven (7) calendar days from the date I open this HSA I may revoke the authorization by mailing a written notice to HSA Bank (set-up fee non-refundable). I assume complete responsibility for: 1) determining that I am eligible for an HSA each year I make a contribution; 2) ensuring that all contributions I make are within the limits set forth by the tax laws (go to www.hsabank.com , click on contribution calculator for help); 3) the tax consequences of any contribution (including rollover contributions) and distributions. By sending this application I agree to all of the preceding and authorize HSA Bank to establish my account.

*** Please keep a copy of this application for your personal records**.

Accountholder Signature **Date**

Authorized Signer / POA Signature **Date**