

# HEALTH SAVINGS ACCOUNT APPLICATION AND ELIGIBILITY FORM

<p><b>For Insurance Agents ONLY</b></p> <p>Affiliation <input style="width: 50px; height: 20px;" type="text"/> <input style="width: 50px; height: 20px;" type="text"/> <input style="width: 50px; height: 20px;" type="text"/> <input style="width: 50px; height: 20px;" type="text"/></p> <p>Code <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/></p> <p>AIN # <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/> <input style="width: 40px; height: 20px;" type="text"/></p> <p>Group Fed ID # <input style="width: 60px; height: 20px;" type="text"/> <input style="width: 60px; height: 20px;" type="text"/> <input style="width: 60px; height: 20px;" type="text"/> <input style="width: 60px; height: 20px;" type="text"/></p> <p>Broker Dealer <input style="width: 60px; height: 20px;" type="text"/> <input style="width: 60px; height: 20px;" type="text"/> <input style="width: 60px; height: 20px;" type="text"/></p>	<p><b>Internal Use:</b></p> <input style="width: 100%; height: 40px;" type="text"/>
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**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**

\* Set-up Fee **\$25.00 for handwritten applications** (ex.    ) or **\$22.00 for machine-readable applications** (ex.    ). Visit [www.hsabank.com](http://www.hsabank.com) or see your healthcare representative for a PDF file you can complete using a computer.

<b>Make Check Payable to HSA Bank</b>	
A. Set-up Fee (See Instructions)*	\$ <input style="width: 40px;" type="text"/>
B. Check Order (\$12.75, if requested)	\$ <input style="width: 40px;" type="text"/>
C. Initial Contribution (Min. \$50)	\$ <input style="width: 40px;" type="text"/>
D. Total Amount Enclosed	\$ <input style="width: 40px;" type="text"/>

**Personal Information:** Please fill in all boxes (MM DD YYYY) (IE: 01 01 2005)

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 (Required)**

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.

**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 an Investment Application. (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)

**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 above, 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.

**Payroll Deductions** Contact your employer to utilize this option

Monthly  Per Payroll Amt. (\$)



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

Employer Name

Federal ID # (Employer Only - Required)

**Eligibility Requirements: REGULAR HSA**

Y  N **Account holder certification-** I certify that: (1) I am or effective \_\_\_\_\_ \* will be covered by a  single or  family qualified High Deductible Health Plan (HDHP), with a deductible of \_\_\_\_\_, (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 entitled to benefits under Medicare, and (4) I may not be claimed as a dependent on another person's tax return.

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.

If you answered NO to the above, you are not eligible to establish a qualified HSA. Please visit [www.hsabank.com](http://www.hsabank.com) for a Non-Qualified HSA application. \* Note: Your application will not be processed until the effective date above. Signatures Required Below

**High Deductible Health Plan Guidelines for 2005**

	Single Coverage	Family Coverage
Minimum Deductible	\$1,000	\$2,000
Maximum Out of Pocket	\$5,100	\$10,200
	Lesser of the annual deductible or:	
Maximum Contribution	\$2,650	\$5,250

**Rules and Conditions**

An HSA is a trust or custodial account owned by the account holder generally created to pay qualifying medical expenses. Contributions can be made to your HSA by you, your employer, or a third party.

\*Additional catch-up contribution is available for individuals 55 or older and not enrolled in Medicare

**Authorized Signer / Power of Attorney (POA) (Optional): Authorized Signer / POA signature required below.**

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 (account holder) hereby designate the following individual as additional authorized signer on my Health Savings Account.

Spouse/Other First

MI Last

Social Security #

Birth Date

**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 signing this Application and per the HSA Account options selected, I am requesting that the Bank issue to my spouse or other authorized third party, as indicated above, a separate debit MasterCard to allow them access to my Health Savings Account and to add their name to my HSA Bank check order to facilitate access to my Health Savings Account.

**Note: Authorized Signer / POA signature required below.**

**Signatures Important: Please read before signing.**

I understand the eligibility requirements for the type of HSA deposit I am making and I state that I do or effective the date above qualified to make the deposit. HSA Bank is hereby appointed to serve as custodian of my Health Savings Account. I have received a copy of the Application, HSA Custodial Agreement and Fee Schedule as they may be amended from time to time. I also agree to the Bank's agreements, rules and regulations, and disclosures applicable to this account and any additional accounts that I establish with the Bank in the future as an individual, custodian or single trustee; this master signature card agreement governing additional account will remain in effect as long as I continuously maintain at least one covered account with the Bank. Within seven (7) calendar days from the date I open this HSA I may revoke the authorization by mailing or delivering a written notice to HSA Bank (set-up fee non-refundable).

**I assume complete responsibility for:**

- Determining that I am eligible for an HSA each year I make a contribution.
- Ensuring that all contributions I make are within the limits set forth by the tax laws. (Go to [www.hsabank.com](http://www.hsabank.com), click on contribution calculator for help.)
- The tax consequences of any contribution (including rollover contributions) and distributions.

**T.I.N. BACKUP WITHHOLDING CERTIFICATION (Cross out item two (2) if subject to backup withholding)**

Under penalties of perjury, I certify that (1) The number shown on this form is my correct taxpayer identification number (T.I.N.)(or I am waiting for a number to be issued to me), (2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest and dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and (3) I am a U.S. person (including a U.S. resident alien).

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Accountholder Signature

Date

Signature of Witness (Required)

Date

(Can be anyone other than a family member or the POA who has witnessed the signing of this form)

Authorized Signer / POA Signature

(Required)

Date

Printed Name of Witness

