**Health Savings Account Application**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | | Soc. Sec. # | Date of Birth | |
| Address | | City | State | Zip |
| Home Phone | Business Phone | | E-Mail Address | |

**Application and Agreement**

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| --- | --- | --- | --- | --- | --- | --- |
| Check One: Self-employed contributing with a personal check should choose Employee Contributions  Self-employed contributing with a business check should choose Employer Contributions   * Employee Only Contributions * Employer Only Contributions (Complete company information below) * Both Employer and Employee are contributing to HSA (Complete company information below) | | | | | | |
| Company Name | | | | Tax ID# | | |
| Address | | City | | | State | Zip Code |
| Contact Person | | | | Phone Number | | |
| **Designation of Beneficiary(ies):** I hereby certify that if I die before distribution has been completed, the value of my Health Savings Account shall be distributed to the Beneficiary(ies) named below. | | | | | | |
| Primary Name | | Address | | City, State, Zip Code | | |
| Percent | Soc. Sec. # | | Relationship | | Date of Birth | |
| Primary Name | | Address | | City, State, Zip Code | | |
| Percent | Soc. Sec. # | | Relationship | | Date of Birth | |
| Contingent Name | | Address | | City, State, Zip Code | | |
| Percent | Soc. Sec. # | | Relationship | | Date of Birth | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Optional:** I hereby designate the following individual as an additional signor on my Health Savings Account to sign checks or use my Debit Card. | | | |
| Authorized Signor Printed Name | | Signature | |
| Social Security # | Date of Birth | | |
| ❒ Yes, I would like to make Direct Deposits to my Health Direct Deposit Amount Day of Month  Savings Account. If “Yes” please include a voided  check from the account you wish to use. $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Health Plan Information:**  ❒ Individual Health Plan ❒ Family Health Plan | | | |
| **Health Insurance Company:** | | | |
| **Annual Deductible $** | | | **Effective Date** |
| Maximum yearly contribution for individuals is 100% of the annual deductible, not to exceed $2600. Maximum yearly contribution for a family is 100% of the annual deductible, not to exceed $5150.  Note: Maximum HSA contributions are based on a full calendar year. Therefore, in the first year, the amount of the contribution is pro-rated on 1/12th basis depending on the effective date of the insurance plan. | | | |
| **BACKUP WITHHOLDING CERTIFICATE:**  By signing below you certify under penalties of perjury:  1. The number shown on this form is my correct taxpayer identification number  2. I am not subject to backup withholding either because I have not been notified that I am subject to backup withholding as a result of failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding. The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding. | | | |
| **Instructions**  You can name one or more persons to be the primary and contingent beneficiaries of your account, including your estate or a trust. Please provide complete information about each beneficiary. If the beneficiary is a trust, please provide the names of the trustees, the date of the trust and the trust's tax ID number. If you designated more than one primary or contingent beneficiary, please be sure that you indicated the percentage share each is to receive and that the percentages add up to 100%.  Any balance left in your account at your death will be paid to the primary beneficiaries in accordance with the share percentages you designate. If the primary beneficiary should predecease you and there are primary beneficiaries who are still living, the deceased beneficiary's share will be distributed to the remaining primary beneficiaries, in proportion to their payment percentage. If not primary beneficiary is living at the time of your death, the valance will be distributed to your contingent beneficiary. If no primary or contingent beneficiary survives you, the balance will be paid to your surviving spouse. If you are not survived by a spouse, we will pay the balance to your estate. If no percentages are indicated for primary or contingent beneficiaries, equal percentages will be assumed.  As disclosed in the HSA Disclosure Statement, your surviving spouse can continue his or her interest in your HSA as his or her own HSA at your death only if he or she is named beneficiary under your HSA. This is the case even if your surviving spouse ultimately obtains a right to assets under your HSA (e.g., your surviving spouse is the sole beneficiary or your estate). If any person other than your spouse is named beneficiary, or any person (including your surviving spouse) otherwise acquires your interest in your HSA on account of death, the HSA portion of the HSA with respect to which there is a non-spouse beneficiary will cease to be a health savings account as of the date of your death. | | | |
| **Health Savings Account Adoption Agreement:**  This agreement when signed by me and accepted by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Trust Company/Custodian Name), for the establishment of a Health Savings Account Custodial Agreement (the "HSA Agreement"). By signing this Agreement I acknowledge:  1.) That there are fees for the\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of Third Party Administrator (TPA)) Health Savings Account.  2.) That I must be covered by a HSA-qualified "high deductible" health plan to be eligible to make HSA contributions (other than rollover contributions) or have HSA contributions made by my employer.  3.) That my HSA has been established for the purpose of paying qualified medical expenses, and if distributions are not used for this purpose, I may be subject to ordinary income and penalty taxes, which I must report to the IRS.  4.) That no loans may be taken from my HSA and no portion of my HSA may be used as security or collateral for a loan.  5.) That I am responsible for reporting my HSA and that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of TPA) has no duty to determine the investment, tax or other consequences resulting from my actions involving my HSA.  6.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of TPA) is not an insurance company who offers the high deductible insurance plans.  7.) I understand I have a 10-day grace period to close my account and receive a full refund. However after 10 days any fees or charges will be non-refundable.  8.) I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Trust Company/Custodian Name) access to my Health Savings Account for the sole purpose of providing end-user support | | | |

❒ Yes, I want to be granted secure online internet access to my Health Savings Account information. You will receive an e-mail from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name of TPA) once your account has been opened with your login information.

**Sign Here** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Primary Account Holder** Date