HEALTH SAVINGS ACCOUNT APPLICATION AND ELIGIBILITY FORM

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

For Tracking Purposes: Complete all that apply.

Affiliation | Broker Dealer | AIN # | Code In. Ong. | SVC | Software

MGA | TPA | Marketing | Employer Fed ID #

Internal Use: Invoice In. Ong.

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***

A. Setup Fee 25.00 **B.** Check Order **C.** Initial Contribution **D.** Total Amount Enclosed

If you are opening this account on your own behalf, please complete all required fields, obtain required signatures, and mail this application to the address listed above. If you have power of attorney privileges for another individual and are opening this account on that individual's behalf, you must complete and submit a Power of Attorney Addendum with this application. Please contact HSA Bank at 800-357-6246 for information and to obtain the necessary form.

Accountholder's Personal Information - *all fields required unless otherwise indicated*

Social Security # - - Birth Date / /

First Name | MI | Last Name

Street Address

City | State | Zip

Preferred Mailing Method ☐ Street Address ☐ PO Box **PO Box (optional)**

P.O. Box City (optional) | **P.O. Box State (optional)** | **P.O. Box Zip (optional)**

Home Phone # - - **Business Phone #** - -

Form of Identification

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

Email (optional)

Citizenship Status (select one): ☐ U.S. Citizen ☐ Resident Alien ☐ Non-resident Alien (If checked, please provide W8)

If not a U.S. Citizen enter Country of Citizenship

Employment Information - *required if employed* ☐ Not Employed ☐ Self Employed

Employer Name BENTON COUNTY

City CORVALLIS **State** OR

Job Title / Profession

Industry (select one)

☐ Agriculture ☐ Construction ☐ Finance, Insurance, Real Estate ☐ Manufacturing ☐ Mining ☐ Professional Services

☒ Public Administration, Government ☐ Retail Trade ☐ Transportation ☐ Wholesale Trade ☐ Other

Income Range (optional)

☐ $0 - $14,999 ☐ $15,000 - $34,999 ☐ $35,000 - $49,999 ☐ $50,000 - $74,999 ☐ $75,000 - $99,999 ☐ $100,000+

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 need you and your authorized signer to provide name, street address, date of birth and other information that will allow us to identify you and your authorized signer. We may also ask to see your driver's license or other identifying documents.

HSA Account Options

☐ I would like to order 50 duplicate checks, including 10 deposit tickets, at a cost of $7.95. (Indicate amount on part B of Instructions section)

☐ I would like 1 free Visa® debit card issued in my name for my account.

☐ I am interested in receiving investment information. (Investment Accounts are Not FDIC Insured. Not Bank Guaranteed. May Lose Value.)

Type of Initial Deposit - *Please check one*

☐ Regular ☐ Rollover/Transfer

(Please attach the HSA transfer/rollover form or IRA rollover form)

Year of Contribution *(Required)*

☐☐☐☐ Enter the plan year.

HSA Eligibility Requirements:

☐ Y ☐ N **Accountholder certification-** I certify that: (1) I am, or effective _____ (*Effective Date of HDHP*) I 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 Health Savings Account.

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 *(Optional)* *Use this space to grant your spouse or a third party access to your account.*

If you wish to designate an authorized signer on your account, please complete all of the required fields below. If you are unable to provide all of the required information on your authorized signer, they will not be added to your account. You hereby designate the following individual as an authorized signer on your Health Savings Account. By designating an authorized signer on your account, you authorize the person designated below as "Authorized Signer" to transact business with and give instructions to HSA Bank regarding your health savings account; make deposits or withdrawals by any means acceptable to HSA Bank, including paper and electronic methods such as ACH and Internet-generated transactions; receive and have access to account information, including account balances and transactions; endorse any instruments such as checks, orders or other documents for the payment of funds; and to otherwise serve as agent for your HSA Bank health savings account.

You specifically authorize HSA Bank, as custodian of your HSA, to rely upon this authorization and designation until such time, if any, that HSA Bank receives a written revocation of this authorization, and has had a reasonable time to act upon the revocation. You understand that you are responsible for ensuring that your authorized signer reads and understands the HSA Bank Account Documents which have been provided to you. You hold harmless and indemnify HSA Bank against any claims against or losses HSA Bank may suffer arising out of HSA Bank's reliance on this authorization, and release HSA Bank from any liability arising from such reliance, unless otherwise prohibited by law. You understand that you bear sole responsibility for any tax consequences that result from any actions taken by the authorized signer regarding your account.

NO PRESENT OR FUTURE OWNERSHIP OR RIGHT OF SURVIVORSHIP IS GIVEN TO THE AUTHORIZED SIGNER BY THIS AUTHORIZATION. UPON NOTICE TO HSA BANK OF YOUR DEATH, THIS AUTHORIZATION TERMINATES, AND RIGHTS TO FUNDS IN YOUR ACCOUNT WILL BE TRANSFERRED TO YOUR BENEFICIARIES. IF YOU DID NOT NAME A BENEFICIARY, YOUR ACCOUNT BALANCE WILL ONLY BE PAYABLE TO YOUR ESTATE.

ALL FIELDS REQUIRED (P.O. Box Not Accepted) - *if designating an authorized signer*

First *(Spouse or Other)* **MI** **Last** *(Spouse or Other)*

Social Security # ☐☐☐ - ☐☐ - ☐☐☐☐ **Birth Date** ☐☐ / ☐☐ / ☐☐☐☐

Street Address (No P.O.Box)

City **State** ☐☐ **Zip** ☐☐☐☐☐

Home Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐

Second Debit Card Option

☐ I would like a second FREE debit Visa® card issued, for the authorized signer listed above.

Designation of Beneficiary

The following individual(s) or entity shall be my primary and/or contingent beneficiary(ies). If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary beneficiary. If more than one primary beneficiary is designated and no distribution percentages are indicated, the beneficiaries will be deemed to own equal share percentages in the account. Multiple contingent beneficiaries with no share percentage indicated will also be deemed to share equally. If a primary or contingent beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining beneficiary(ies) shall be increased on a pro-rated basis. If no primary beneficiary(ies) survives me, the contingent beneficiary(ies) shall acquire the designated share of my account. I understand that I may change or add beneficiaries at any time by completing and delivering the proper form to HSA Bank. HSA Bank has provided no tax or legal advice to me regarding my beneficiary designation.

Name & Address of Individual *(or of Trust and Trustee)*	**Date of Birth** *(Creation date, if Trust)*	**Social Security #** *(TIN, if Trust)*	**Relationship**	**Primary or Contingent**	**Share %**
				☐ Primary ☐ Contingent	
				☐ Primary ☐ Contingent	

**To designate additional beneficiaries please visit our website (http://www.hsabank.com/accountholders/forms.asp) for a designation of beneficiary form.*

Spousal Consent

This section should be reviewed if either the trust or the residence of the Accountholder is located in a community or marital property state and the Accountholder is married. Due to important tax consequences of giving up one's community property interest, individuals signing this section should consult with an independent legal or tax advisor.

CURRENT MARITAL STATUS

☐ I am not married - I understand that if I become married in the future, I must complete a new Designation of Beneficiary form.
☐ I am married - I understand that if I chose to designate a primary beneficiary other than my spouse, my spouse must sign below.

I am the spouse of the above-named Accountholder. I acknowledge that I have received a fair and reasonable disclosure of my spouse's property and financial obligations. Due to the important tax consequences of giving up my interest in this account, I have been advised to see a tax professional. I hereby give the Accountholder any interest I have in the funds or property deposited in this account and consent to the beneficiary designation(s) indicated above. I assume full responsibility for any adverse consequences that may result. No tax or legal advice was given to me by the Custodian.

Signature of Spouse **Date** **Signature of Witness (Required-Cannot be Spouse)** **Date**

Signatures *Important: Please read before signing.*

HSA Bank is hereby appointed to serve as custodian of my Health Savings Account. HSA Bank, a 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 *Deposit Account Agreement and Disclosures for Health Savings Accounts, Truth in Savings, and Privacy Statement.* 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).

Accountholder Signature **Date** **Authorized Signer** **Date**

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Contribution Form Below

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HSA Contribution Form

Instructions: **Use this Contribution Form to deposit funds in your Health Savings Account with HSA Bank. Complete this form and mail with your contribution check to**: HSA Bank, P.O. Box 939, Sheboygan, WI 53082-0939.
After your transaction is completed, you can review your transactions in any of the following ways: via your statement, Internet Banking or Bankline (800) 565-3512. Internet Banking and Bankline provide access 24 hours a day, 7 days a week.

Accountholder Information:

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

Street Address

City **State** **Zip**

Account # (8 digits, from your statement)* **Social Security #**

(Account# or Social Security #Required)

Please include your account number on your check.

Contribution Information:

Contribution Amount:

$. Per Pay Period

Contribution Source:

☐ Account holder and/or family member
☐ Employer
☐ Employee pre-tax (through Section 125 Plan)

Contribution For:

☐ **Current Year** *(yyyy)*
OR
☐ **Prior Year** *(yyyy)*

NOTE: Prior year deposits must be in your account by your tax-filing deadline(typically April 15), NOT including extensions. If no year is specified, your contribution will be deposited for the year in which it was received.

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