



# Health Savings Account (HSA) Application and Eligibility Form

**Instructions:** Complete all fields below. Mail your application to: HSA Bank, P.O. Box 939, Sheboygan, WI 53082.  
For assistance, call (800) 357-6246, Monday - Friday, 7 a.m. - 9 p.m., CT. Para ayuda en Español, por favor de llamar (866) 357-6232.

## PART 1: GENERAL INFORMATION FOR PRIMARY ACCOUNTHOLDER

First Name:	MI:	Last Name:	Date of Birth: (mm/dd/yyyy)	Social Security Number:
Street Address: (Required)		City:	State:	ZIP Code:
Preferred Mailing Address: <input type="checkbox"/> Street Address <input type="checkbox"/> P.O. Box		Email:		
P.O. Box:	City:	State:	ZIP Code:	
Home Phone:	Business Phone:		Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employment: <input type="checkbox"/> Employed <input type="checkbox"/> Not Employed <input type="checkbox"/> Self-Employed <input type="checkbox"/> Retired				
Employer:			Title/Profession:	
Health Plan Insurance: <input type="checkbox"/> Single <input type="checkbox"/> Family		Effective Date of your Health Insurance:	Deductible Amount: \$	

## PART 2: AUTHORIZED SIGNER OPTIONAL: (SUCH AS A SPOUSE OR ANOTHER THIRD PARTY)

By completing all of the fields below, you are authorizing the person designated as "Authorized Signer" to access and initiate transactions on your account as your agent. HSA Bank will rely upon this designation until HSA Bank receives your written revocation of this authorization and has had a reasonable time to act upon it. You hold harmless and indemnify HSA Bank against any claims against or losses 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 remain solely responsible for any tax consequences that result from any actions taken by the authorized signer regarding your account.

First Name:	MI:	Last Name:	Date of Birth: (mm/dd/yyyy)	Social Security Number:
<input type="checkbox"/> Address same as accountholder		Street Address:		
City:	State:	ZIP Code:	Phone Number:	

If you would like to designate a beneficiary for your account, please complete our Designation of Beneficiaries form which is available on our website at: <http://www.hsabank.com/beneficiary>. 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 BE PAYABLE THROUGH YOUR ESTATE.

## PART 3: ACCOUNT SELECTIONS

Please select the account options and enter an amount where appropriate.

Primary Accountholder debit card (No Charge)  
 Authorized Signer debit card (if applicable) (No Charge)  
 Checks (\$7.95 - check must be included to process order.) \$ \_\_\_\_\_  
 Initial Contribution \$ \_\_\_\_\_ Contribution Year \_\_\_\_\_  
 Transfer:  Yes  No (if yes, please attach the HSA transfer/rollover form or IRA form.)

## PART 4: ACCOUNT AUTHORIZATION

By signing below, I certify that:

- I am, or will be covered by a qualified High Deductible Health Plan (HDHP), I am not enrolled in Medicare or covered under other health insurance that is not compatible with an HSA, and I may not be claimed as a dependent on another person's tax return (excluding spouses per the IRS).
- HSA Bank is hereby appointed to serve as custodian of my Health Savings Account.
- 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. HSA Bank, a division of Webster Bank, N.A. and Webster Bank, N.A. are the same FDIC-insured institution. Within seven (7) calendar days from the date I open this HSA, I may revoke authorization for opening the account by mailing a written notice to HSA Bank.
- To help the government fight the funding of terrorism and money laundering activities, Federal Law requires that all financial institutions 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.

Accountholder Signature:			Date:					
For Tracking Purposes (to be completed by employer or insurance/financial representative)					Internal Use Only:			
Health Plan Code	Broker Dealer	AIN#	SVC	Software	MGA	Marketing	Employer Fed ID #	
		7109				1008859	860294012	

## HEALTH SAVINGS ACCOUNT DESIGNATION OF BENEFICIARIES

**Instructions:** Please complete this form and mail or fax it to:

*HSA Bank, P.O. Box 939, Sheboygan, WI 53082-0939, FAX: (877) 851-7041*

**Accountholder Information:**

First Name           MI  Last Name

(8 digits, from your statement)

Account #         Social Security #         Birth Date

mm/dd/yyyy

**Designation Type:** Please check one of the following options.

- Initial Beneficiary Designation :** I designate the individual(s) or entity named below as my primary and/or contingent beneficiary(ies) of this HSA.
- Replace Beneficiary(ies):** I designate the individual(s) or entity named below as my primary and/or contingent beneficiary(ies) of the account named above and hereby revoke all prior beneficiary(ies) designations, if any, made by me.
- Add Beneficiary(ies):** I designate the individual(s) or entity named below as my primary and/or contingent beneficiary(ies) of the account named above. This list supplements, but does not replace, the beneficiary(ies) previously designated by me on the date specified. (When adding beneficiaries, if the share % of previously designated beneficiary(ies) changes, restate all beneficiary(ies) and the corresponding share % if the previous percentages are no longer correct.)

**Designation of Beneficiaries:**

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.

Name & Address of Individual (or of Trust and Trustee)	Date of Birth (mm/dd/yyyy) <small>(creation date, if Trust)</small>	Social Security # <small>(TIN, if Trust)</small>	Relationship	Primary or Contingent	Share %
				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	

**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) (Must be 18 or older.)	Date
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**Signatures**

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.

Signature of Accountholder	Date	Signature of Witness (Required-Cannot be spouse) (Must be 18 or older.)	Date
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