



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

Employer Name

Employer Contact Name

Mailing Address

Type of Business

City

State

Zip

**Rules and Conditions Applicable to HSA**

**GENERAL INFORMATION:** An HSA is a trust or custodial account which is created exclusively for the benefit of the HSA holder and which is generally used to pay qualifying medical expenses. If you are eligible, contributions can be made to your HSA by you, your employer, or a family member. Qualifying distributions from your HSA are tax-free.

**DEFINITIONS:** High Deductible Health Plan (HDHP) generally means, as defined in IRC Section 223(c)(2), a health plan, which satisfies the following requirements regarding deductibles and expenses for Tax year 2004: (a) For single coverage, the deductible must not be less than \$1,000 with annual out-of-pocket expenses not exceeding \$5,000, or (b) for family coverage, the deductible must not be less than \$2,000 with annual out-of-pocket expenses not exceeding \$10,000. The maximum amount of contributions in any one year that can be made is the lesser of: the annual deductible or \$2,600 for single coverage, and the annual deductible or \$5,150 for family coverage. Catch-up contributions may also be made by or on behalf of individuals who are 55 years old or older and younger than 65.

**NOTE:** You will receive your HSA account information and welcome kit once we process your application. If your application is received incomplete, it will not be processed until we receive all items or the application may be returned. (Please see instructions on previous page.)

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

Since regulations require that only one individual own an HSA account, the account owner 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 HSA account to be used for normal distributions only.

**HSA Bank** is hereby appointed to serve as custodian of my Health Savings Account.

I agree to be bound by the account rules and regulations applicable to the Health Savings Account established by the Application and Agreement 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 accounts will remain in effect as long as I continuously maintain at least one covered account with the Bank.

By signing this Application and per the HSA Account options selected above, 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 electronic 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 as of the date I entered on the previous page will qualify to make the deposit. I have received a copy of the Application and the **HSA Custodial Agreement**. I understand that the terms and conditions which apply to this HSA are contained in this Application and the Agreement. I agree to be bound by those terms and conditions. Within seven (7) calendar days from the date I open this HSA I may revoke it by mailing or delivering a written notice to the custodian of the account (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.hsabankusa.com](http://www.hsabankusa.com), click on contribution calculator for help.)
3. 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.

HSA Holder Signature

Date

Signature of Witness (Required)

Date

(Must not be the same as the Authorized Signer / POA)

Authorized Signer / POA Signature

Date

Printed Name of Witness

