Health Savings Account (HSA) Application and Eligibility Form

hsabank®
A Division of Webster Bank, N.A., Member FDIC

Instructions: Complete all fields below. Mail or fax your application to: **HSA Bank, P.O. Box 939, Sheboygan, WI 53082, Fax: 920-803-4184**
For assistance, call 800-357-6246, Mon - Fri, 7 a.m. - 9 p.m., Sat, 9 a.m. -1 p.m., CT. Para ayuda en Español, por favor llamar 866-357-6232.

PART 1: GENERAL INFORMATION FOR PRIMARY ACCOUNTHOLDER

First Name:	MI:	Last Name:	Date of Birth **(must be 18)**: (mm/dd/yyyy)	Social Security Number **(Required)**:
Physical Street Address: **(Required)**			City: State:	ZIP Code:
Preferred Mailing Address ☐ Physical Street Address ☐ P.O. Box			Email:	
P.O. Box:			City: State:	ZIP Code:
Home Phone:			Business Phone:	
Citizenship Status ☐ U.S. Citizen ☐ Resident Alien ☐ Non-resident Alien			If not a U.S. Citizen, enter Country of Citizenship:	
Employment: ☐ Employed ☐ Not Employed ☐ Self-Employed ☐ Retired				
Employer:			Title/Profession:	
Health Plan Insurance: ☐ Single ☐ 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:
☐ 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. If you fail to designate a beneficiary, then your estate will be your beneficiary upon your death.

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.
- 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.

After your application is processed, you will receive a Welcome Kit by mail in 7-10 business days. The Welcome Kit contains your account number and our disclosures. It also outlines our services and provides details on how to manage your account. If you don't receive your Welcome Kit, please contact us.

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 #
							620331040