

**Health Savings Account
Enrollment Package**

Member FDIC

ELIGIBILITY REQUIREMENTS (REQUIRED):

Answer the following four questions to determine if you are eligible for a Health Savings Account (HSA).

- | | | |
|---|-------------------------------|--------------------------------|
| 1. I am covered under a Qualified High Deductible Health Plan (QHDHP). | <input type="checkbox"/> TRUE | <input type="checkbox"/> FALSE |
| 2. I am not covered by a health plan, other than a QHDHP, which provides any of the same benefits as the QHDHP. | <input type="checkbox"/> TRUE | <input type="checkbox"/> FALSE |
| 3. I am not eligible for Medicare (age 65) or if I am eligible, I am not enrolled in Part A or B. | <input type="checkbox"/> TRUE | <input type="checkbox"/> FALSE |
| 4. I am not dependent on another person's tax return. | <input type="checkbox"/> TRUE | <input type="checkbox"/> FALSE |

If you answered FALSE to any of the four questions above DO NOT CONTINUE. You are not eligible to open a Health Savings Account. By signing and submitting this application you affirm your eligibility to establish a Health Savings Account.

IMPORTANT INFORMATION ABOUT OPENING AN ACCOUNT:

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 for you. When you open an account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see a copy of your driver's license, social security card or other identifying documents.

RULES AND CONDITIONS APPLICABLE TO HEALTH SAVINGS ACCOUNTS:

General Information: An HSA is a 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, you or your employer can make contributions to your HSA. 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 2007:

- (a) For single coverage, the deductible must not be less than \$1,100, with annual out-of-pocket expenses not exceeding \$5,500, or
- (b) For family coverage, the deductible must not be less than \$2,200, with annual out-of-pocket expenses not exceeding \$11,000. The maximum amount of contributions in any one-year that can be made \$2,850 for single coverage, and \$5,650 for family coverage.

Refer to the IRS or to our website, <https://www.americanchartered.com/personalHealthSavings.aspx>, for the current year limits. In general catch up contributions for a spouse must be made into a separate HSA account opened in the name of the spouse.

PERSONAL INFORMATION (REQUIRED):

Name: _____
(First) (Initial) (Last)

Social Security Number: _____ Birth Date: _____

Address Line 1: _____

(U.S.Patriot Act regulations require that we obtain a valid street address from all new customers. If you use a PO Box for mailing purposes, you must also provide us with a valid street address for verification purposes. Your account will not be opened without this information.)

Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Business Phone #: _____

Form of Identification: Driver's License State ID Passport ID Number: _____

ID Issue Date: _____ ID Expiration Date: _____ ID State of Issue: _____

Mothers Maiden Name: _____ City of Birth: _____ State of Birth: _____

E-Mail Address (Required for Online Banking and E-Statements): _____

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ACCOUNT TYPE / OPENING DEPOSIT (REQUIRED):

Type of Account Desired (Choose one):

HSA Checking HSAs Investment Account (Mutual Fund Option) Certificate of Deposit/Term: _____

Please indicate HDHP insurance coverage (Choose one): Individual Family

Deposit Type: Regular – Contribution Year: _____ Rollover* Custodian to Custodian Transfer*

*Attach Rollover/Transfer Form

ADDITIONAL HEALTH SAVINGS ACCOUNT PRODUCT & SERVICE OPTIONS:

I would like to order personalized checks for my HSA Account. Please including a separate check made payable to American Chartered Bank for the check-printing fee of \$13.45 for single checks or \$15.45 for duplicate checks. **(Checks are not offered with HSA Certificate of Deposits)**

I would like a free Visa Check Card* issued in my name. **(Visa Check Cards are not offered with HSA Certificate of Deposits)**

I would like to activate online banking for my account I would like to activate online banking and bill pay for my account
(Online Banking is required with the HSA Investment Account option)

I would like to receive Electronic Statements (E-Statements). **American Chartered Bank assigns your E-Statement password. The password will be the first five (5) characters of the email address you are providing to us plus the last four (4) digits of your social security number.**

** Please Note: Purchases made with either a Visa Check Card or checks will be reported by the Bank as "normal distributions" for the year in which the transaction is posted to the account. You should not use your Visa Check Card or checks for non-qualifying or non-medical purpose. You may be subject to IRS penalties if you do. We ask that you submit an HSA withdrawal form when requesting a non-qualifying or non-medical distribution. This form is available on our website at <https://www.americanchartered.com/personalHealthSavings.aspx>.*

DESIGNATION OF AUTHORIZED SIGNER (optional, not applicable with CDs):

If you wish grant your spouse or a third party access to your account as an Authorized Signer please complete all the required fields below and have the Authorized Signer sign the signature card where indicated.

Name: _____
(First) (Initial) (Last)

Address: _____

Social Security Number: _____ Birth Date: _____

Form of Identification: Driver's License State ID Passport ID Number: _____

State of Issue: _____ ID Issue Date: _____ ID Expiration: _____

Mother's Maiden Name: _____ City of Birth: _____ State of Birth: _____

I authorize American Chartered Bank to issue an additional Visa Check Card on my account to the authorized signer designated above. If more than one person signs this application, all such persons agree to be jointly and severally liable for the performance of the obligations set forth in the Visa Check Card Agreement, to be sent with the cards. I acknowledge I will be liable for the use of the Visa Check Card by the authorized signer.

EMPLOYER INFORMATION:

Employer Name: _____

Employer Contact Name: _____

Employer Contact Number: _____ Address: _____

City: _____ State: _____ Zip Code: _____

DESIGNATION OF BENEFICIARIES:

The following individual(s) or entity shall be my primary and/or contingent beneficiary(s). 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(s) shall be increased on a pro-rated basis. If no primary beneficiary(s) survives me, the contingent beneficiary(s) shall acquire the designated share of my account.

Name and Address	Date of Birth	Social Security #	Relationship	Primary or Contingent	Share (Percent)
				<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 the residence of the Account Holder is located in a community or marital property state, and the Account Holder is married. Due to important tax consequences of giving up one's community property interest, individual's signing below should consult with a competent legal or tax advisor.

- 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 choose to designate a primary beneficiary other than my spouse, my spouse must sign the spousal consent portion on the attached signature card and my spouse's signature must be witnessed by someone other than myself.

RULES AND REGULATIONS

American Chartered Bank is hereby appointed to serve as custodian of my Health Savings Account.

By signing the attached signature card 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; the master signature card agreement governing additional accounts will remain in effect as long as I continually maintain at least one account with the Bank.

I understand the eligibility requirements for the type of HSA deposit that I am making, and I state that I do 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 the HSA, I may revoke it by mailing or delivering a written notice to the custodian of the account.

I assume complete responsibility for:

- (1) Determining that I am eligible for a HSA each year I make a contribution
- (2) Ensuring that all contributions I make are within the limits set forth by the tax laws
- (3) The tax consequences of any contribution (including rollover contributions) and distributions.
- (4) I authorize American Chartered Bank to release to my employer account related information necessary to support the posting of contributions to my Health Savings account including account number, social security number and bank routing information.

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The Bank must receive a signed signature card before completing the account opening process.

AMERICAN CHARTERED BANK			
HSA OWNER'S NAME	DATE	# OF SIG REQ.	ACCOUNT NUMBER (For Bank Use Only)
		One	
HSA ACCOUNT OWNER'S ADDRESS			
HSA ACCOUNT OWNER'S SIGNATURE			SOCIAL SECURITY #
AUTHORIZED SIGNER'S SIGNATURE (if applicable)			SOCIAL SECURITY #
<p>The depositor acknowledges receipt of a copy of the rules or regulations regulating this account and agrees to be bound by them and by any amendments to them. The depositor has read and certifies under provision of perjury to the truthfulness of the tax withholding certificate appearing below. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding. Signatures shown above are specimen or facsimile signatures of person(s) authorized to effect transactions on this account by the current depository resolution that filed with the Bank. If Single Name Account: This account is owned by the party named hereon.</p> <p>TAX WITHHOLDING CERTIFICATE: Under penalties of perjury, the depositor certifies (1) that the tax identification number shown on this form is the depositor's correct tax payer identification number and that (2) the depositor is not subject to backup withholding either because (a) the depositor is exempt from such withholding, (b) the depositor has not been notified that the depositor is subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the Internal Revenue Service has notified the depositor that the depositor is no longer subject to backup withholding. **Strike the part (2) of this paragraph if the depositor has been notified that the depositor is subject to backup withholding due to underreporting and has not received a notice from the Internal Revenue Service that backup withholding has terminated.</p> <p>Account number release: I authorize American Chartered Bank to release to my employer account related information necessary to support the posting of electronic credits to my Health Savings account including account number, SSN and bank routing information.</p> <p>By signing this card I acknowledge that I have read and agree to all the conditions contained in this HSA account application. I also authorize American Chartered Bank to release to my employer account related information necessary to support the posting of contributions to my Health Savings account including account number, SSN, and bank routing information.</p>			

SPOUSAL CONSENT FORM:
Complete this section <u>only</u> if the HSA Account Owner is married and their spouse <u>has not</u> been designated as the primary beneficiary.
*SIGNATURE OF SPOUSE:
SIGNATURE OF WITNESS: (Cannot be HSA account holder or spouse):
<p>* I am the spouse of the above-named Account Holder. 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 Account Holder 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. The Custodian gave no tax or legal advice to me.</p>