



## *Health Savings Account Application*

### 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, the Bank will ask for your name, residence 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.

### ELIGIBILITY REQUIREMENTS:

**To be eligible\* for a Health Savings Account (HSA) you must,**

- ✓ Be covered under a Qualified High Deductible Health Plan (QHDHP).
- ✓ Not be covered by a health plan, other than a QHDHP, which provides any of the same benefits as the QHDHP.
- ✓ Not be eligible for Medicare (age 65) or if eligible, not be enrolled in Part A or B.
- ✓ Not be a dependent on another person's tax return.

\*You may open an HSA if you are transferring HSA funds from another custodian even if you don't meet all four of the above criteria. However, you may no longer be qualified to make additional contributions. We recommend confirming this with your tax advisor.

### 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 years 2010 & 2011:

	Minimum Deductible		Defined Max Out-Of-Pocket Expenses		Maximum HSA Contribution	
	2010	2011	2010	2011	2010	2011
Individual	\$1,200	\$1,200	\$5,950	\$5,950	\$3,050	\$3,050
Family	\$2,400	\$2,400	\$11,900	\$11,900	\$6,150	\$6,150

Individuals who are 55 or older and are covered under a high deductible health plan are eligible for an additional \$1,000 catch-up contribution for 2009 and later years. 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): TYPE OR PRINT CLEARLY

Name: \_\_\_\_\_  
(First) (Initial) (Last)

Social Security Number: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Residence Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**U.S. Patriot Act regulations require that we obtain a valid residential street address from all new customers. If you use a PO Box as an alternate mailing address, you must also provide us with a valid residential street address for verification purposes. Your account will not be opened without this information. In an effort to avoid additional address verification follow up, you may include a copy of your drivers license, a utility bill, or a paystub showing your current residential street address.**

Mailing Address: (If Different from Home Address) \_\_\_\_\_

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: \_\_\_\_\_

City & State where you were born: \_\_\_\_\_, \_\_\_\_\_ Your mother's maiden name: \_\_\_\_\_  
(City) (State)

E-Mail Address (Required for Online Banking and E-Statements): \_\_\_\_\_ @ \_\_\_\_\_



## *Health Savings Account Application*

### ACCOUNT TYPE / OPENING DEPOSIT (REQUIRED):

Type of Account Desired (Check One. If left blank the default will be HSA Checking)

HSA Checking       HSA CD / Term: \_\_\_\_\_

Please indicate HDHP insurance coverage :     Individual     Family    Insurance Plan Effective Date: \_\_\_\_\_

If including a deposit please indicate type:     Regular – Contribution for Calendar Year: \_\_\_\_\_     Rollover  
(If left blank the default will be a regular contribution for the current year)

### HSA FEATURES AND ADDITIONAL PRODUCTS & SERVICES:

I would like a free HSA Debit Card\* issued in my name.

I would like to order personalized checks for my HSA Account\*. Please include a separate check made payable to American Chartered Bank for the check-printing fee of \$19.50 for single checks or \$22.00 for duplicate checks. (Check printing fees are subject to change without notice.)

**Free Online Banking:** You can self enroll in Online Banking by visiting the bank's web site [www.americanchartered.com](http://www.americanchartered.com) and clicking on 'ENROLL IN ONLINE BANKING' found in the Online Banking section of the home page. To enroll you will need your account number which will arrive in your welcome packet.

**Free E-Statements and E-Notices:** Your HSA features FREE electronic statements and notices sent password protected to your email address using Adobe Acrobat's 128-bit data security encryption. Your HSA will be assigned a nine (9) digit E-Statement password. The password will be the **first five (5) characters of your email address (in CAPITAL letters) plus the last four (4) digits of your SSN**. If you prefer to receive paper statements or you have not provided us with a valid email address your HSA will be charged a \$1.50 monthly paper statement fee.

Please send monthly paper statements and charge my account the \$1.50 monthly paper statement fee. (Fee does not apply to HSA Investment Checking)

*\* Purchases made with checks or an HSA Debit Card will be reported to the IRS as "normal distributions" for the year in which the transaction posts to your account. You should not use your HSA Debit 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 (available only on HSA Checking accounts):

Health Savings Accounts are owned individually, however, you can name your spouse or other third party individual as an Authorized Signer on your HSA. If you wish to name an Authorized Signer, complete all the fields below. Your Authorized Signer must sign the HSA signature card where indicated.

Authorized Signer's Name: \_\_\_\_\_  
(First) (Initial) (Last)

Residence Street 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 HSA Debit Card on my account in the name of 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 HSA Debit Card Agreement, to be sent with the cards. I acknowledge I will be liable for the use of the HSA Debit Card by the authorized signer.

### EMPLOYER INFORMATION:

Employer Name: \_\_\_\_\_

Employer Contact Name: \_\_\_\_\_

Employer Contact Number: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_



## *Health Savings Account Application*

### 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.

Beneficiary Name and Address	Date of Birth	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	

### 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 understand and agree to be bound by the rules and regulations which apply to Health Savings Accounts as established by this Application and the HSA Custodial Agreement and any amendments to them. I also agree to be bound by the Bank's agreements, rules, regulations, and disclosures applicable to this account and any additional accounts that I establish with the Bank in the future.

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.

The HSA Custodial Agreement and all account disclosures will be provided at account opening. If this account is opened electronically or through the mail they will be mailed to me no later than 10 business days after this account is opened.

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.

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.

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.



- ✓ To order personalized checks mark the appropriate box and include a check payable to American Chartered Bank the printing charge. Check printing charges are listed in the application.
- ✓ To fund your account at opening include your initial deposit with this signature card. Make the check payable to American Chartered Bank.

<b>American Chartered Bank HSA - SIGNATURE CARD</b>		
HSA ACCOUNT HOLDER NAME (PRINTED)	DATE OPENED	ACCOUNT NUMBER:
	For Bank Use Only	For Bank Use Only
HSA ACCOUNT HOLDER ADDRESS (PRINTED)		TYPE OF ACCOUNT: <input type="checkbox"/> HSA Checking  <input type="checkbox"/> HSA CD
<p>By signing this signature card I acknowledge that I have read and agree to all the conditions contained in the American Chartered Bank HSA account application and agree to be bound by the rules and regulations regulating this account as described in the Custodial Agreement, account disclosures and by any amendments to them. I authorize American Chartered Bank to release to my employer any account related information necessary to support the posting of contributions to my Health Savings Account including account number, SSN, and bank routing information. I authorize <b>Great Lakes HSA</b>, who is acting as my agent, to submit this Health Savings Account application in my name to American Chartered Bank. I attest to the accuracy of all information provided in the application. <b>American Chartered Bank is not affiliated with Great Lakes HSA</b> and as such, I agree to release and waive any and all claims that I have, or may have at any time in the future, against American Chartered Bank for any act or omission, taken or failed to be taken, by Great Lakes HSA regarding the administration of my account. 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. The signature(s) shown below is a specimen signature of the person(s) authorized to effect transactions on this account. This account is owned by the party named hereon.</p> <p><b>TAX WITHHOLDING CERTIFICATE:</b> 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. <b>**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.</b></p>		
HSA ACCOUNT HOLDER SIGNATURE		SOCIAL SECURITY #
AUTHORIZED SIGNER SIGNATURE (if applicable)		SOCIAL SECURITY #

<b>SPOUSAL CONSENT FORM:</b>
<p>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.</p>
*SIGNATURE OF SPOUSE:
SIGNATURE OF WITNESS: (Cannot be the 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>