Office Use Only: Date Account Opened __________ Account Number __________________ Agent ID#: 00082
Date Application Received: __________________ Date Funds Received __________________ Fee Code ________

Home Federal Bank
500 12th Ave. South
P. O. Box 190
Nampa, Idaho 83653-0190

HEALTH SAVINGS ACCOUNT APPLICATION

ACCOUNT OWNER INFORMATION: (Please Print Clearly)

Name ______________________ Social Security # ______________________ Date of Birth __________

Mailing Address ______________________ City __________ State ______ Zip ________

Physical Address **(NOT A P.O. Box)** ______________________ City __________ State ______ Zip ________

Home Phone (_____) ______________ Work Phone (_____) ______________ Fax (_____)______________

Driver's License #______________ State of Issuance ______________ Expiration Date __________

Date of Issue ______________ Mother's Maiden Name/Password ______________________

****** MUST INCLUDE A COPY OF YOUR DRIVER'S LICENSE W/APPLICATION (*or other government issued id)**

Name of Employer ____

Mailing Address ______________________ City __________ State ______ Zip ________

Work Phone (_____) ______________ Fax (_____)______________ Type of Business ______________

OPENING DEPOSIT: $90.00 minimum. (Make check payable to Home Federal, includes $40.00 annual fee.)

Initial Contribution $__________ Tax Year 20 _____

Is this a rollover? Yes ☐ No ☐ Amount of rollover contribution $__________

In the case of a rollover from an MSA/HSA, I certify that this contribution is a rollover contribution within the meaning of Internal revenue Code Section 220, that the rollover is being made within 60 days of receipt, and this is my only rollover in the last 12 months.
For calendar year 2005, the maximum annual contribution limit for an account owner with single coverage is the lesser of the amount of the deductible under the HDHP but not more than $2,650. For calendar year 2005, the maximum annual contribution limit for an account owner with family coverage is the lesser of the amount of the deductible under the HDHP but not more than $5,250. These limits are subject to cost-of-living increases after 2005. Contributions to Archer MSAs or other HSAs count toward the maximum annual contribution limit to this HSA.
For calendar year 2005, an additional $600 catch-up contribution may be made for an account owner who is at least age 55 and less than age 65. The catch-up contribution increases to $700 in 2006, $800 in 2007, $900 in 2008, and $1,000 in 2009 and later years. Contributions in excess of the maximum annual contribution are subject to an excise tax. However, the catch-up contributions are not subject to an excise tax.

POWER OF ATTORNEY (Optional): (Since regulations require that only one individual owns the HSA, the account owner may want his or her spouse or dependant child through Power of Attorney to write checks or use their check card.) **I (account owner or principal) hereby designate my spouse or dependant child named below as my attorney-in-fact with respect to my HSA account, including, but not by way of limitation, the powers to write checks and use their check card to make withdrawals.** This power of attorney shall not be affected by subsequent disability or incapacity of the principal. For additional information, please refer to the Customer Account Agreement.

Name ______________________ Social Security # ______________ Date of Birth __________

☐ Please issue second check card in name and for use by my attorney-in-fact

BENEFICIARY (IES) DESIGNATION: (In the event of my death, I name as):

Primary Beneficiary(ies) (total of shares percents must equal 100%)

Name ______________________ Social Security # ______________ Date of Birth __________

Mailing Address ______________________ City ______________ State ______ Zip ______

Relationship______________________ Share (Percent of holding) _____%

Name ______________________ Social Security # ______________ Date of Birth __________

Mailing Address ______________________ City ______________ State ______ Zip ______

Relationship______________________ Share (Percent of holding) _____%

Secondary Beneficiary(ies) (total of shares percents must equal 100%)

Name ______________________ Social Security # ______________________ Date of Birth ____________

Mailing Address ______________________ City ______________________ State______ Zip ________

Relationship______________________ Share (Percent of holding) _____%

Name ______________________ Social Security Number ______________________ Date of Birth____________

Mailing Address ______________________ City______________________ State ______ Zip ________

Relationship______________________ Share (Percent of holding) _____%

The above designations are subject to the Conditions of Beneficiary Designation listed below:

CONDITIONS OF BENEFICIARY DESIGNATION:

1. This designation is subject to all terms and provisions of the agreement and shall be effective only if received by the custodian prior to the death of the person executing it.
2. This designation applies to the account holder's entire interest, if any, in custodial account assets remaining undistributed at the account holder's death.
3. Each payment to be made pursuant to this designation: (a) shall be paid to the primary beneficiary or beneficiaries who are living at the time of the account holder's death, (b) if no primary beneficiary is living at the time, such payment shall be made to the secondary beneficiary or beneficiaries who are then living at the time of the account holder's death (c) if percentage shares are not filled in above, payments to joint primary or secondary beneficiaries shall be in equal shares.
4. This designation may be changed only by filing a written Change of Beneficiary Designation with the custodian.

SPOUSAL CONSENT:(For use in community property or marital property states including: AZ, CA, ID, LA, NV, NM, TX, WA, WI)

If you are married, reside in a community property or marital property state, and designate someone other than your spouse as your sole primary beneficiary, your spouse must sign below. In addition, if required in your state, the form must be signed in the presence of a Notary Public. I am the spouse of the above named HSA owner. 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 HSA, I have been advised to see a tax professional. I hereby give the HSA owner any interest I have in the funds or property deposited in this HSA 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.

Spouse Signature (required in community or marital property states) ______________________ Date ____________

ACCEPTANCE OF TERMS:

By my signature below, I apply, and the institution by its signature accepts my application to establish a Health Savings Account pursuant to the terms of the Home Federal Health Savings Account Custodial Account Agreement, Customer Account Agreement and the Services Charges and Fees brochure, which are incorporated into this application by reference.

IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING A NEW 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 your driver's license or other identifying documents.

X______________________________ X______________________________

Signature of Account Holder Date Signature of Attorney-in-Fact Date

Broker Use Only
Broker Name: John Baird / ASAP Flex Plans Business Phone Number (____)________________/ID# 00082