



# HEALTH SAVINGS ACCOUNT APPLICATION AND ELIGIBILITY FORM

For Insurance Agents ONLY			Internal Use:		
Affiliation	<input type="text"/>	Code	Group Fed ID #	<input type="text"/>	<input type="text"/>
AIN #	<input type="text"/>	In. Ong.	Broker Dealer	<input type="text"/>	

**Instructions:** All fields must be completed. For assistance, call 800-357-6246. (Para un formulario en Español por favor contactar 866-357-6232). Return this Application with a check to: **HSA Bank™, P.O. Box 939, Sheboygan, WI 53082-0939**

\* Set-up Fee **\$25.00 for handwritten applications** (ex. **HSA**) or **\$22.00 for machine-readable applications** (ex. **HSA**). Visit [www.hsabank.com](http://www.hsabank.com) or see your healthcare representative for a PDF file you can complete using a computer.

**Make Check Payable to HSA Bank**

A. Set-up Fee (See Instructions)*	\$	<input type="text"/>
B. Check Order (\$12.75, if requested)	\$	<input type="text"/>
C. Initial Contribution (Min. \$50)	\$	<input type="text"/>
D. Total Amount Enclosed	\$	<input type="text"/>

**Personal Information:** Please fill in all boxes (MM DD YYYY) (IE: 01 01 2005)

Social Security #  Birth Date

First Name  MI  Last Name

Street Address (Required)

PO Box  City

State  Zip  Preferred Mailing Method  Street Address  PO Box

Home #  Bus. #

**Form of Identification (Required)**

Driver's License  State ID  Passport ID#

Email

*If email address is provided, HSA Bank will send an email confirmation following account opening. All accounts will also receive a Welcome Kit by mail within 2 weeks of account opening.*

*Note: 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 to you: When you open an account we will ask for your name, street address, date of birth and other information that will allow us to identify you. We may request a copy of your driver's license or other identifying documents.*

**HSA Account Options:**

*Please read Power of Attorney section for spousal or third party access to your HSA.*

*Purchases made with either the debit MasterCard® or HSA Bank checks will be reported by the Bank as "normal distributions" and should only be used for qualified medical expenses. I understand I am responsible for any IRS penalties. I understand that I should submit an HSA withdrawal form for any non-qualifying or non-medical transaction at a cost of \$4.00 per occurrence. I understand the bank will issue me a check. I understand I must pay a monthly fee of \$2.25 for this account. The fee is waived each month for accounts that maintain a balance greater than \$3,000 during the entire month period.*

I would like to order 50 non-duplicate checks, including 10 deposit tickets, at a cost of \$12.75. (Indicate amount on part B of Instructions section above)

I would like 1 free debit MasterCard issued in my name for my account.

I would like to be enrolled in internet banking. (Email address required above for this option)

I am interested in receiving an Investment Application. (Non FDIC Insured: Stocks, Bonds, and Mutual Fund Options)

**Initial Contribution Source and Amount**

Accountholder and/or Third Party Deposit Total "Above the Line" Deductions (after tax) Amt. (\$)

Employer Contribution Pre-tax Deduction Amt. (\$)

Employee Pre-Tax through Section 125 Plan Contact your employer to utilize this option Amt. (\$)

**Total Initial Contribution Amount** (Indicate amount on part C of Instructions section above) (\$)

**Payroll Deductions** Contact your employer to utilize this option

Monthly  Per Payroll Amt. (\$)

**Type of Initial Deposit - Please check one**

Regular-Year of Contribution (Required)

Rollover/Transfer (Please attach transfer/rollover form)

**Employer Consent**

My employer wishes to have access to my HSA Bank account information in order to facilitate direct deposit of employer contributions to my account. I, as named above, authorize my employer to obtain my account information; for the sole purpose of facilitating direct contributions to my account. I hold harmless and indemnify the Bank against any claims against or losses Bank may suffer arising out of Bank reliance on this authorization and release Bank from all liability arising from such reliance. This authorization remains in full force and effect until Bank receives written notice of revocation and has had a reasonable time to act upon such notice.

My employer is not authorized to facilitate deposits to my account.



