

Health Savings Account Application and Eligibility Form								113dVd11K _®		
Health Savings Account (HSA) o		_	mployer –	Upon co	ompletio	n, submit this fo	rm to your emplo		bster Bank, N.A., Member FDIC	
Employer Federal Tax ID or Em HSA not offered through an em			a at beabe	ndi som		rm to beafarms	@haahank oom fa	v form to		
920-803-4184 or mail this form							@fisabank.com, ra	x ioriii to		
or assistance, please call 800-357-		,	, .	70	,					
Required										
Part 1: General Information for	Primary	/ Accountho	older							
*First Name:	MI:	*Last Name	:		*Date	e of Birth (mm/dd	/yyyy) (Must be 18):	*Social Security Number:		
*Physical Street Address:						*City:		*State:	*ZIP:	
*Preferred Mailing Address: Phy	sical Stree	et Address	P.O	. Box	Emai	:		'		
P.O. Box:					'	City:		State:	ZIP:	
*Home Phone:					Busir	ess Phone:		'		
*Citizenship Status: U.S. Citizen Resident Alien Non-Resident Alien					en Coun	Country of Citizenship if Not a U.S. Citizen:				
*Health Plan Insurance: Single	ealth Plan Insurance: Single Family/Single + Dependent(s) *Effective Date of the Dependent of the Dependen					our Health Insura	ance:	*Deductible Amount: \$		
Part 2: Employment Informatio		,	yer fede	ral tax I	D or emp	oloyer code abo	ove is <u>required</u> fo	r an employer	offered HSA.)	
*Employment Status: Employed	Self-e	mployedI	Not Emplo	yed/Retir	ea .	oyer Name: red if employed/self-	employed)			
Part 3: Authorized Signer (Such	as a spo	ouse or ano	ther third	d party)	Option					
otherwise prohibited by law. You remain	losses arising out of HSA Bank's reliance on this autin solely responsible for any tax consequences that rauthorized signer to your account, all fields in this solely. MI: Last Name:				that result	from any actions ta	ken by the authorized	-		
Address same as accountholder			Street A	ddress:						
City: State:					ZIP:		Phone Number:			
If you would like to designate a beneficia					-		•			
hsabank.com/BeneficiaryForm. Alternati designate a beneficiary, then your estate				ry for you	r account o	n HSA Bank's Mem	ber Website after you	r account is opene	d. If you fail to	
Part 4: Account Selections	,	·								
*Please select the account options and e	nter an an	nount where a	nnronriate							
Primary accountholder debit card	incer an an	nount where a	рргорпасс.							
Authorized signer debit card (if app	licable)									
Initial contribution \$ Transfer (Include the Health Saving.	s Account	Direct Transfer		bution Yea		Transfer Form				
Transfer (medade the ricater saving.	3 Account 1	Direct Transjer	nequestro	in or the	ma to risa	Trunsjer romi.,				
Part 5: Account Authorization										
By signing below, I certify that:										
 I am or will be covered by an HSA-qua and I may not be claimed as a depend HSA Bank is hereby appointed to serv Federal law requires that all financial your authorized signer to provide nan 	dent on ano re as custod institutions me, street a	ther person's ta lian of my Healtl s obtain, verify, a	x return (exon Savings Acon and record in	cluding spo count. nformation	ouses per the	e IRS). fies each person who	o opens an account. Wh	en you open an acc	count, we will need you an	
driver's license or other identifying do After your application is processed, you w services and provides details on how to r	vill receive									
business days after your application is pro *Accountholder Signature:										
		an imaurana 10	namaia!				Date.	lata l l /	0.1	
For Tracking Purposes (to be completed by			-					Internal Use	Unly:	
Health Plan Code Broker Dealer	AIN#	S\	/C	Softwa	ire	MGA	Marketing			
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