

A. Accountholder Information All fields are required

Please note: As a part of the U.S. Patriot Act of 2001, financial institutions must verify the identity of any person seeking to open an account. If the information provided in Section A cannot be verified via the ID verification process, we will contact you to obtain documentation to validate the accuracy of the information. HSA funds will be on hold until the ID verification hold has been cleared. If not cleared within 60 days of notice, your HSA will be closed and any funds returned to the originating account.

Please Print Clearly To Ensure Your Account Is Set Up Accurately!

Name: (Last, First, MI)			Social Security Number:
Street Address: (Cannot be PO Box)			
City:	State:	Zip Code:	Day Phone: ()
E-mail Address:			Date of Birth:
<i>Required to receive important account notifications</i>			
Date of Hire:	Gender: F M	Division (if applicable):	

B. Medical Plan Information For the HSA-Qualified High Deductible Health Plan (HDHP)

HDHP Effective Date:	<input type="checkbox"/> I understand an HSA is an Individual Account	HDHP Coverage Level: <input type="checkbox"/> Self Only <input type="checkbox"/> Family/Other
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C. HSA Effective Date

Please indicate your HSA effective date. The chart below can help you determine your appropriate effective date.

If HDHP Effective Date Is:	And HSA Application Signature Date Is:	The HSA Effective Date Can Be:
First of month Example: January 1	On or prior to HDHP effective date Example: December 15	HDHP effective date or any later date Example: January 1 or later date
First of month Example: January 1	After HDHP effective date Example: January 2	Date of application or any later date Example: January 2 or later date
Other than first of month Example: January 15	On or before 1 st of month following HDHP effective date Example: January 25	1 st of month following HDHP effective date or later Example: February 1 or later date
Other than first of month Example: January 15	After the 1 st of month following HDHP effective date Example: February 2	Date of application or any later date Example: February 2 or later date

HSA Effective Date:

D. Debit Card

You will automatically receive a set of two identical debit cards that you can use to access HSA funds when paying at the point of service/sale or when paying a bill. Debit cards will be mailed to your home address in an envelope that looks like this.

You will sign the back of one card and an eligible dependent can sign the back of the other card for his/her use. Additional and replacement cards can be ordered by contacting Benefit Strategies at 888-401-3539 or info@benstrat.com. Fee may apply.



E. Distribution Request

You can request a distribution of funds from your HSA easily through your secure online account at benstrat.com. You can also complete and submit the HSA Distribution form. The form can be downloaded from benstrat.com or you can contact Benefit Strategies to have the form sent to you. Indicate below how you would like to receive the funds when you request a distribution.

Direct Deposit – **No fee.** Please complete below. Check – **\$5.00 fee** applies for each check distribution.

Direct Deposit Information														
Bank Name: (See #1 on sample)	<input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account	<table border="1"> <tr> <td>Account Holder's Name Address, Etc.</td> <td>Check Number</td> </tr> <tr> <td>Transit Code</td> <td>ex: 23-94/1062</td> </tr> <tr> <td colspan="2"> <table border="1"> <tr> <td>1 Bank Information</td> <td>2 Name of Bank</td> <td>3 Address, Phone</td> </tr> <tr> <td>4 Digit Routing Number</td> <td colspan="2">5 Checking Account Number If</td> </tr> </table> </td> </tr> </table>	Account Holder's Name Address, Etc.	Check Number	Transit Code	ex: 23-94/1062	<table border="1"> <tr> <td>1 Bank Information</td> <td>2 Name of Bank</td> <td>3 Address, Phone</td> </tr> <tr> <td>4 Digit Routing Number</td> <td colspan="2">5 Checking Account Number If</td> </tr> </table>		1 Bank Information	2 Name of Bank	3 Address, Phone	4 Digit Routing Number	5 Checking Account Number If	
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Routing Number: 9 digits (See #2 on sample): <table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>										Account Number:(See #3 on sample): _____				

*Your email address will not be shared, sold or used for purposes other than contacting you regarding your HSA.

F. Beneficiary Designation

I designate the following individual(s) or entity as my primary or contingent death beneficiary(ies) of this HSA.

If I am married in common law or in a community or marital property state, I must designate my spouse as Primary Beneficiary unless my spouse's signature is obtained and notarized below.

Share percentages must equal 100% for primary and 100% for contingent.

1. Name:		Social Security Number:
Address: (City, State Zip)		Date of Birth:
<input type="checkbox"/> Primary <u>or</u> <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	Share Percentage:
2. Name:		Social Security Number:
Address: (City, State Zip)		Date of Birth:
<input type="checkbox"/> Primary <u>or</u> <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	Share Percentage:
3. Name:		Social Security Number:
Address: (City, State Zip)		Date of Birth:
<input type="checkbox"/> Primary <u>or</u> <input type="checkbox"/> Contingent	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	Share Percentage:

Please check one of the following:

- I am not married. If I become married at a future date, I understand I must complete a new Beneficiary Designation form.
- I am married. I understand that if I choose to designate a primary beneficiary other than my spouse, he or she must agree to the designation by signing below. My spouse's signature must be notarized.

Notarized Signature of Spouse:
(Only required if spouse is
waiving beneficiary rights)

Date:

Subscribed and sworn to before me this _____ day of _____ 20____

Notary Public

G. Signature And Acknowledgements

By executing this form:

✓ I acknowledge that I understand I will receive an HSA confirmation email from Benefit Strategies with account login instructions and I am then responsible for logging in to my account at www.benstrat.com accepting Terms and Conditions. I understand that until I do so, I will not have any access to contributions made to my HSA from any source.

✓ I acknowledge that I will read the HSA Disclosure Statement and HSA Custodial Agreement (including Privacy Policy) online at www.benstrat.com and agree to receive future notices of updates by visiting www.benstrat.com, and to review the Custodial Agreement (and Privacy Policy) no less frequently than annually. (Privacy Policy can also be viewed by visiting www.healthcarebank.com)

✓ I understand that by opening an HSA I am consenting to receive electronic documents, including the monthly HSA Account Statement, and that if I want to opt out of electronic documents I can do so by requesting the change through the Statements & Notifications area of my secure account at www.benstrat.com and. A fee may apply for each paper HSA Account Statement sent.

Employee Signature:

Date: