HSA BANK®
National Leader in Health Savings Accounts.
A Division of Webster Bank, N.A., Member FDIC

Health Savings Account (HSA) Application and Eligibility Form

Instructions: Complete all fields below. Mail or fax your application to: **HSA Bank, P.O. Box 939, Sheboygan, WI 53082, Fax: (920) 803-4184**
For assistance, call (800) 357-6246, Monday - Friday, 7 a.m. - 9 p.m., CT. Para ayuda en Español, por favor llamar (866) 357-6232.

PART 1: GENERAL INFORMATION FOR PRIMARY ACCOUNTHOLDER

First Name:	MI:	Last Name:	Date of Birth: (mm/dd/yyyy)	Social Security Number:

Street Address: **(Required)**	City:	State:	ZIP Code:

Preferred Mailing Address: ☐ Street Address ☐ P.O. Box	Email:

P.O. Box:	City:	State:	ZIP Code:

Home Phone:	Business Phone:

Citizenship Status: ☐ U.S. Citizen ☐ Resident Alien ☐ Non-resident Alien *(If checked, please provide W8)*	If not a U.S. Citizen, enter Country of Citizenship:

Employment: ☐ Employed ☐ Not Employed ☐ Self-Employed ☐ Retired

Employer:	Title/Profession:

Health Plan Insurance: ☐ Single ☐ Family	Effective Date of your Health Insurance:	Deductible Amount: $

PART 2: AUTHORIZED SIGNER *OPTIONAL: (SUCH AS A SPOUSE OR ANOTHER THIRD PARTY)*

By completing all of the fields below, you are authorizing the person designated as "Authorized Signer" to access and initiate transactions on your account as your agent. HSA Bank will rely upon this designation until HSA Bank receives your written revocation of this authorization and has had a reasonable time to act upon it. You hold harmless and indemnify HSA Bank against any claims against or losses arising out of HSA Bank's reliance on this authorization, and release HSA Bank from any liability arising from such reliance, unless otherwise prohibited by law. You remain solely responsible for any tax consequences that result from any actions taken by the authorized signer regarding your account.

First Name:	MI:	Last Name:	Date of Birth: (mm/dd/yyyy)	Social Security Number:

☐ Address same as accountholder	Street Address:		
City:	State:	ZIP Code:	Phone Number:

If you would like to designate a beneficiary for your account, please complete our Designation of Beneficiaries form which is available on our website at: http://www.hsabank.com/beneficiary. UPON NOTICE TO HSA BANK OF YOUR DEATH, THIS AUTHORIZATION TERMINATES, AND RIGHTS TO FUNDS IN YOUR ACCOUNT WILL BE TRANSFERRED TO YOUR BENEFICIARIES. IF YOU DID NOT NAME A BENEFICIARY, YOUR ACCOUNT BALANCE WILL BE PAYABLE THROUGH YOUR ESTATE.

PART 3: ACCOUNT SELECTIONS

Please select the account options and enter an amount where appropriate.

☐ Primary Accountholder debit card (No Charge)

☐ Authorized Signer debit card *(if applicable)* (No Charge)

☐ Checks ***($7.95 – check must be included to process order.)*** $ _____

☐ Initial Contribution $ _____ Contribution Year _____

Transfer: ☐ Yes ☐ No (*If yes, please attach the HSA transfer/rollover form or IRA form.)*

PART 4: ACCOUNT AUTHORIZATION

By signing below, I certify that:

- I am, or will be covered by a qualified High Deductible Health Plan (HDHP), I am not enrolled in Medicare or covered under other health insurance that is not compatible with an HSA, and I may not be claimed as a dependent on another person's tax return (excluding spouses per the IRS).
- HSA Bank is hereby appointed to serve as custodian of my Health Savings Account.
- I have received a copy of and agree to the Deposit Account Agreement and Disclosures for Health Savings Accounts, Truth in Savings, and Privacy Statement. HSA Bank, a division of Webster Bank, N.A. and Webster Bank, N.A. are the same FDIC-insured institution. Within seven (7) calendar days from the date I open this HSA, I may revoke authorization for opening the account by mailing a written notice to HSA Bank.
- To help the government fight the funding of terrorism and money laundering activities, Federal Law requires that all financial institutions 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 need you and your authorized signer to provide name, street address, date of birth and other information that will allow us to identify you and your authorized signer. We may also ask to see your driver's license or other identifying documents.

Accountholder Signature: **Date:**

For Tracking Purposes (to be completed by employer or insurance/financial representative) | **Internal Use Only:**

Health Plan Code	Broker Dealer	AIN#	TPA	SVC	Software	MGA	Marketing	Employer Fed ID #
								43-0549050

HSA Employee Contribution Form

BeneFLEX HR RESOURCES INC.

Return Completed Form to:
Email: hsaprocessing@beneflexhr.com or Fax: 314-909-6983

Company		**Employee Name**	

A. Employee Contribution Calculation

Please use this section to help determine the maximum amount that can be contributed to your HSA for the current plan year.

A) **ANNUAL DEDUCTIBLE AMOUNT** of high-deductible health plan for ☐ SINGLE ☐ FAMILY coverage is:	$
B) **MAXIMUM ANNUAL HSA CONTRIBUTION*** Enter the maximum you wish to contribute.	$
C) **CATCH UP CONTRIBUTION**** (if applicable):	$
D) **EMPLOYER CONTRIBUTION** (if applicable):	$
E) **MAXIMUM EMPLOYEE CONTRIBUTION** Add line B and line C, then subtract line D:	$

IMPORTANT:
* Participants may contribute up to $3,350 Individual or $6,650 Family (for 2015) regardless of the deductible amount. The annual maximum may be contributed regardless of the amount of the plan deductible. Partial year enrollees may also contribute the annual maximum without tax penalties as long as they remain HSA-eligible for 12 months following December 31st of the year in which the contribution was made.

** If you are age 55 or older, you may make an additional "catch-up" contribution to your HSA over and above the annual IRS maximum. The catch-up maximum for 2015 is $1,000, and is not pro-rated by the number of months you are enrolled for that particular plan year.

Note: Total tax deductible contributions must be credited to the HSA account by April 15 of the following calendar year. Participants in an HSA generally cannot be covered by another health plan (other than the high deductible health plan), except with respect to certain types of "permitted" insurance. See HSA Overview for more information.

B. Employee Contribution Election

Type of Employee Contribution for 2015 **Plan Year** (Check only one. Provide ***your*** contribution amount only). Annual Election should be no greater than the total of E above.

☐ **Pre-tax through your employer's Cafeteria Plan**: Your employer will reduce your taxable wages by the amount of your contributions. You benefit by paying less in federal income (10-35%) and FICA (7.65%) taxes.

$_____ x _____ = $_____
Per Payperiod Contribution | Number of Payperiods | Annual Election

☐ **Post-tax**:

$_____ x _____ = $_____
Per Payperiod Contribution | Number of Payperiods | Annual Election

C. Employer Contribution Election

☐ **Post-tax**:

$_____ x _____ = $_____
Per Payperiod Contribution | Number of Payperiods | Annual Election

D. Signature

I authorize my employer to withhold the appropriate amounts from my salary to cover this contribution as specified above.

_____
Account Owner (Print) **Signature** **Date**

BeneFLEX HR Resources, Inc.
10805 Sunset Office Drive, Suite 401 St. Louis, MO 63127 | Email: info@beneflexhr.com |Website: www.beneflexhr.com