Health Savings Account (HSA) Application and Eligibility Form

hsabank®
A Division of Webster Bank, N.A., Member FDIC

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, Mon - Fri, 7 a.m. - 9 p.m., Sat, 9 a.m. -1 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 **(must be 18)**: (mm/dd/yyyy)	Social Security Number **(Required)**:
Physical Street Address: **(Required)**			City: State:	ZIP Code:
Preferred Mailing Address ☐ Physical 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 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. If you fail to designate a beneficiary, then your estate will be your beneficiary upon your death.

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.
- 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.

After your application is processed, you will receive a Welcome Kit by mail in 7-10 business days. The Welcome Kit contains your account number and our disclosures. It also outlines our services and provides details on how to manage your account. If you don't receive your Welcome Kit, please contact us.

Accountholder Signature:	**Date:**

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

Health Plan Code	Broker Dealer	AIN#	SVC	Software	MGA	Marketing	Employer Fed ID #

Employer Sign-Up Form

Instructions: All fields are required unless otherwise noted. Please complete this form using your computer or print clearly, then fax it to Business Relations at 920-803-4184. Be sure to keep a copy of this form. You will need your username to log in to the Employer Administration Site.

By completing the Employer Sign-Up Form, you will gain access to HSA Bank's Employer Administration Site, which is designed to help you manage your Health Savings Account (HSA) program. You can also make online contributions to employee accounts through this site. A summary of your enrollment and contribution options will be emailed to you, along with your temporary password, within 3-5 business days. If you have questions, please contact us at 866-357-5232.

COMPANY INFORMATION

Company Name:		Employer Federal Tax ID#:
Address:		P.O. Box:
City:	State:	ZIP Code:
Phone:	Fax:	Company URL:
Number of Employees:	Number of Employees Electing an HSA:	Effective Date of HDHP: (mm/dd/yyyy)

Do you want participants assigned to divisions for reporting purposes?
☐ Yes ☐ No (If Yes, please provide a primary contact for divisions.)

PRIMARY CONTACT INFORMATION

The Primary Contact is the only individual who will have full administrative rights. If you wish to change your Primary Contact in the future, you must complete an Employer Change Form, which can be requested by calling Business Relations at 866-357-5232.

First Name:		Last Name:
Phone:	Extension:	Fax:
Email:		

HSA Bank will provide you with login information to access the Employer Administration Site.

Is the Invoicing Contact the same as the Primary Contact? ☐ Yes ☐ No

** If your Primary Contact and Invoicing Contact are not the same, please provide the Invoicing Contact's information below.*

INVOICING CONTACT INFORMATION

First Name:		Last Name:
Phone:	Extension:	Fax:
Email:		

HSA Bank will provide you with login information to access the Employer Administration Site.

PERMISSIONS BASED ON TITLE (IF GRANTED EMPLOYER PORTAL ACCESS)

Primary Contacts: Access to employee data* and reporting, as well as the ability to import demographic, enrollment, and contribution files.

Invoicing Contacts: "View only" access to employee data and reporting

*Employee data includes name, address, date of birth, marital status, gender, last four digits of SSN, username, employment information, and total employer contributions.

SET UP PREFERENCES

For information on your options, visit www.hsabank.com, select the Employer tab, and click on Determine Enrollment Method or Select Contribution Options. Additional information will also be included in your Welcome Email and Employer Manual. If you would like to change your enrollment method, please call Business Relations at 866-357-5232.

Would you like to be invoiced for your employees' monthly fees?* ☐ Yes ☐ No

**Term of the final negotiated contract, if applicable, would govern.*

For HSA Bank Use Only			**Welcome Kit Code:**
Health Plan Code:	**AIN:**	**Marketing:**	**BP ID:**
Service Code:	**Broker Dealer:**	**TPA:**	**MGA:**

Employer Sign-Up Form

Instructions: All fields are required unless otherwise noted. Please complete this form using your computer or print clearly, then fax it to Business Relations at 920-803-4184. Be sure to keep a copy of this form. You will need your username to log in to the Employer Administration Site.

By completing the Employer Sign-Up Form, you will gain access to HSA Bank's Employer Administration Site, which is designed to help you manage your Health Savings Account (HSA) program. You can also make online contributions to employee accounts through this site. A summary of your enrollment and contribution options will be emailed to you, along with your temporary password, within 3-5 business days. If you have questions, please contact us at 866-357-5232.

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

I hereby authorize HSA Bank , hereinafter called BANK, to initiate debit entries to COMPANY's ☐ Checking Account/ ☐ Savings Account (select one) on file with BANK or indicated in the banking information section of this form, hereinafter called DEPOSITORY, and to debit the same to such account for payment of the monthly invoiced Health Savings Account service fees for our employees. (An email notification will be sent to you with online access to your invoice at least 8 days in advance of your monthly scheduled payment dates. Your monthly invoices and employee list will be available online at the Employer Administration Site.) I acknowledge that the origination of ACH transactions to COMPANY's account must comply with the provisions of U.S. law.

BANKING INFORMATION		
Depository Name:		Branch:
Address:		Phone:
City:	State:	ZIP Code:
Routing Number:		Account Number:
Type of Account: ☐ Checking Account ☐ Savings Account		

AUTHORIZATION	
The authorization is to remain in full force and effect until the BANK has received written notification from me (or either of us) of its termination in such time and in such manner as to afford BANK and DEPOSITORY a reasonable opportunity to act on it.	
Name(s):	Title:
Signature:	Date:
NOTE: ALL WRITTEN DEBIT AUTHORIZATIONS MUST PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.	