Health Savings Account Application

Tallahassee State Bank
2720 W. Tennessee Street
Tallahassee, FL 32304

HSA OWNER INFORMATION *REQUIRED FIELDS

1

NAME		HSA ACCOUNT NUMBER (for bank use only)
*FIRST:		
*MI:		*SOCIAL SECURITY NUMBER (SSN)
*LAST:	SUFFIX:	

HOME ADDRESS (No PO Boxes)		MAILING ADDRESS (if different from home/street address)	
*ADDRESS 1:		ADDRESS 1:	
ADDRESS 2:		ADDRESS 2:	
*CITY:		CITY:	
*STATE:		STATE:	
*ZIP:		ZIP:	

*DAYTIME PHONE NUMBER (7065551212)	*E-MAIL (REQUIRED)	*DATE OF BIRTH mm/dd/yyyy	*GENDER	
			O MALE	O FEMALE
*HOME PHONE NUMBER (7065551212)	*MOTHER'S MAIDEN NAME			

*Type of Health Insurance Plan Coverage (select one):	O Self-Only	O Family

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 must ask you for your name, street address (no P.O. Boxes), date of birth, and other information that will identify you. We may also ask to see your driver's license or other identifying documents.

Two forms of identification are required: 1) one photo ID (driver's license, passport, or alien registration card), and 2) a copy of one of the following: major credit card, utility bill, or insurance voucher.

***Identification Type** (select one): O Driver's License O Passport O Alien Registration Card

*A. STATE/COUNTY OF ISSUANCE	*B. IDENTIFICATION NUMBER	*C. DATE ISSUED mm/dd/yyyy	*D. EXPIRATION DATE mm/dd/yyyy

2 **CONTRIBUTION AND CONTRIBUTOR INFORMATION**

Please complete this section only if mailing a contribution with this account application.

A. ACCOUNT NUMBER	B. INITIAL CONTRIBUTION AMOUNT	C. CONTRIBUTION DATE mm/dd/yyyy	D. TAX YEAR yyyy

E. CONTRIBUTION TYPE (select one):

O Regular	O Catch-Up (age 55 or older and not enrolled in Medicare)
O Rollover from a Health Savings Account	O Rollover from an Archer Medical Savings Account
O Transfer from a Health Savings Account	O Transfer from an Archer Medical Savings Account
O Contribution from an IRA	O Rollover from A Health Reimbursement Arrangement/Health Flexible Spending Account
O Return of Mistaken Distribution	

F. Contributor Relationship to HSA Owner (select one): O HSA Owner O Employer O Family Member O Other:

3 DESIGNATION OF BENEFICIARY

At the time of my death, the primary beneficiaries named below will receive my HSA assets. If all of my beneficiaries die before me, the contingent beneficiaries named below will receive my HSA assets. In the event a beneficiary dies before me, such beneficiary's share will be reallocated on a pro-rata basis to the other beneficiaries that share the deceased beneficiary's classification as a primary or contingent beneficiary. If all of the beneficiaries die before me, my HSA assets will be paid to my estate. If no percentages are assigned to beneficiaries, the beneficiaries will share equally among the beneficiaries within such class. This designation revokes and supersedes all earlier beneficiary designations which may apply to this HSA.

A. Primary Beneficiary

PERCENTAGE	NAME OF BENEFICIARY	SSN OR TAXPAYER IDENTIFICATON NUMBER	RELATIONSHIP TO HSA OWNER
			select one
			select one
			select one

TOTAL 100%

B. Contingent Beneficiary

PERCENTAGE	NAME OF BENEFICIARY	SSN OR TAXPAYER IDENTIFICATON NUMBER	RELATIONSHIP TO HSA OWNER
			select one
			select one
			select one

TOTAL 100%

4 SPOUSAL CONSENT

_____ (HSA Owner Initials) **I Am Married**. I understand that if I designate a primary beneficiary other than my spouse, my spouse must consent by signing below.

_____ (HSA Owner Initials) **I Am Not Married**. I understand that if I marry in the future, I must complete a new Designation of Beneficiary form, which includes the spousal consent documentation.

I am the spouse of the HSA owner. Because of the significant consequences associated with giving up my interest in the HSA, the custodian has not provided me with legal or tax advice, but has advised me to seek tax or legal advice. I acknowledge that I have received a fair and reasonable disclosure of the HSA owner's assets or property, including any financial obligations for a community property state. In the event I have a legal interest in the HSA assets, I hereby give to the HSA owner such interest in the assets held in this HSA and consent to the beneficiary designation sets forth in section 3 of this form.

✍✗ _____ Signature of Spouse Date

✍✗ _____ Signature of Witness (if required) Date

5 AUTHORIZED SIGNER INFORMATION

Visa® HSA Card: A Visa® HSA Card will be issued in my name to access my HSA.

☐ I request that one (1) Visa® HSA Card be issued in the name of the Authorized Signer set forth in Section 6 below for purposes of accessing funds in my HSA. **{Complete the Authorized Signer Section below.}**

I agree: 1) to be bound by the terms and conditions of the deposit account agreement and Visa® HSA Card Agreement; 2) to use the Cards exclusively for the purpose of paying my or my family's qualified medical expenses; 3) all Cards, periodic statements, and other notices will be mailed to the HSA owner's mailing address designated on this application; 4) I am responsible for any losses to the issuer of the Cards resulting from use of the Cards including, but not limited to, lost or stolen cards or used by an Authorized Signer; 5)to notify the HSA custodian immediately of lost or stolen Cards or any unauthorized use of the Cards; 6) I am responsible for activating and distributing Cards to Authorized Users.

HSA Checks: To order checks to access your HSA, please call 1-877-367-4HSA after your HSA is opened.

I acknowledge and agree that only one individual may own an HSA. Notwithstanding the foregoing, I hereby make, designate, and appoint the following individual as an authorized signer ("Authorized Signer") on my HSA for the purposes of accessing funds in my HSA. By providing the Authorized Signer information below, I hereby request and authorize that a Visa® HSA Card be issued in the name of the Authorized Signer.

A. NAME AND ADDRESS OF AUTHORIZED SIGNER		B. AUTHORIZED SIGNER SSN
NAME:		
ADDRESS:		C. AUTHORIZED SIGNER DOB mm/dd/yyyy
CITY:		
STATE:		
ZIP:		

D. AUTHORIZED SIGNER SIGNATURE

✍✗ _____ Signature of Authorized Signer Date

6 DEPOSIT INVESTMENTS

By signing in section 8 below, I authorize and direct you to invest funds in my HSA in deposit investments. By signing below, I 1) agree to the terms stated in this Application; 2) authorize you, at your sole discretion, to verify credit and employment information and/or to have a credit reporting agency prepare a credit report on me; and 3) agree that this Application will serve as the signature card for my deposit investment. **{Complete the Backup Withholding Certification section below.}**

.

7 BACKUP WITHHOLDING CERTIFICATIONS

Under penalties of perjury, I certify that:

1. The number shown on this application is my correct taxpayer identification number, and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

Signature _____ Date

8 SIGNATURES

If this HSA is being established with a regular contribution, I certify that I am covered by a qualified high deductible health plan (HDHP), and that I am not covered by a health plan other than HDHP that provides any of the same benefits as an HDHP. If this HSA is being established with a rollover or transfer contribution, I certify that the rollover or transfer of assets is from another HSA or Archer Medical Savings Account (MSA). I certify that the information provided by me on this Application is accurate, and that I have received a copy of the Application, Health Savings Custodial Account and Disclosure Statement, Truth in Savings Disclosure, Schedule of Fees & Charges, Deposit Account Agreement for Health Savings Account, Funs Availability Policy, Visa Health Savings Account Card Agreement, 2005 Privacy Policy, and Substitute Check Policy Disclosure (Check 21). I agree to be bound by the terms and conditions found in the Application, Health Savings Custodial Account, Disclosure Statement, and amendments thereto. I assume sole responsibility for all consequences relating to my actions concerning this HSA. I understand that I may revoke this HSA on or before seven (7) days after the date of establishment. I have not received any tax or legal advice from the custodian, and I will seek the advice of my own tax or legal professional to ensure my compliance with applicable laws. I release and agree to hold the HSA custodian harmless from and against any and all claims or losses arising from my actions.

Signature of HSA Owner _____ Date

Signature of Custodian _____ Date

NOTE: YOUR APPLICATION WILL NOT BE PROCESSED UNTIL WE HAVE RECEIVED ALL OF THE INFORMATION REQUIRED ON THIS APPLICATION. YOUR HSA ACCOUNT WILL NOT BE OPENED UNTIL WE HAVE RECEIVED YOUR SIGNED APPLICATION AND THE REQUIRED FORMS OF IDENTIFICATION.
Please mail your completed Application to: HSA Operations, P.O. Box 1828, Columbus, GA 31901-1828.

For Bank Use Only

Bank Number	Branch Number	Cost Center	Primary Officer & Number	Secondary Officer & Number
965	**0001**	**0001**	**001**	**001**

Service Charge Plan	Tracking Code (where applicable)
018	**florida965**

PLEASE CLICK HERE TO READ AND PRINT DISCLOSURE STATEMENT

Please note: You will not be able to submit the application until this has been completed.

I have read the agreements and disclosures above. By clicking the "I agree" button below, I signify my acceptance of the terms and conditions of those agreements and disclosures. I understand and agree that if you accept my application to open the account, I will be bound by those terms and conditions.

A "Printer Friendly" version of this form will be available for printing at the end of this process.

○ I AGREE ○ I DO NOT AGREE

○ I AGREE ○ I DO NOT AGREE

DON'T FORGET TO PRINT DISCLOSURE!

Submit Application

Submit Application