



HEALTH SAVINGS ACCOUNT Application and Custodial Agreement

PLEASE NOTE: Do not use a coversheet if faxed. Fax will go into secured inbox. Bar code must be visible on first page for processing.

PERSONAL INFORMATION			
Name		SSN	
Physical Address		DOB (mm/dd/yyyy)	
City, State, Zip		Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married
Mailing Address (if different)		Driver's License #	
City, State, Zip		Issuing State	
Home Phone	Work Phone	Cell Phone	
Email address			

Important Information about Procedures for Opening a New Account:

To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: When you open an account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

HEALTH PLAN INFORMATION			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you covered by an HSA qualified high deductible plan (HDHP)? (If you answer no, you are not eligible to establish an HSA.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you covered by any other non-permitted health plan? (See www.afhsa.com for definitions & examples)
Carrier Name		<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you covered by Medicare?
Effective date of HDHP	Yearly Deductible \$	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you claimed as a dependent on another person's tax return?
Type of Coverage	<input type="checkbox"/> Individual <input type="checkbox"/> Family	(If you answered yes to any of the questions above, you are not eligible to establish an HSA. See IRS Publication 969 for specific information.)	

EMPLOYER INFORMATION (if you are establishing the HSA separate from your employer, this information does not need to be completed)			
Company Name		Contact	
Address		Telephone Number	
City, St, Zip		Date of Employment	

CONTRIBUTION INFORMATION				
Requested effective date for the HSA: _____				
(The requested effective date cannot be sooner than the date this application is signed, effective date of coverage under the HDHP or the date you are eligible to contribute to an HSA.)				
Contribution	Annual	Per Pay Period	Pay Period (if applicable)	[2016] Maximum Annual Contribution: Individual = [\$3,350] Family = [\$6,750]
Employer	\$ _____	\$ _____	<input type="checkbox"/> Monthly <input type="checkbox"/> Bi-monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly	[2017] Maximum Annual Contribution: Individual = [\$3,400] Family = [\$6,750]
Individual	\$ _____	\$ _____		For additional information on what may affect your annual allowable contribution(s), please visit www.afhsa.com .
Catch-up Contribution	\$ _____	\$ _____		Account owners age 55+ may make an additional contribution of \$1,000/year.

REQUEST FOR ADDITIONAL DEBIT CARD (Optional)

Would you like a second debit card for use by an authorized user – either a spouse or an eligible dependent* - at no additional fee? Yes No

*Dependent must be 18 years or older.

Name		Relationship	
Social Security #		DOB (mm/dd/yyyy)	

Check this box if you would like to list the above person as a signatory on your HSA.

A MasterCard will automatically be mailed to your home address shown above. The debit card can be used with merchants with a valid medical merchant code. By requesting a secondary debit card, you are agreeing that the secondary debit card is subject to the HSA custodial agreement, all other conditions of the account, and all law governing HSA accounts.

BENEFICIARY INFORMATION

Name		Relationship		<input type="checkbox"/>	Primary
Address		DOB		<input type="checkbox"/>	Contingent
City, St, Zip				___%	Percent
Name		Relationship		<input type="checkbox"/>	Primary
Address		DOB		<input type="checkbox"/>	Contingent
City, St, Zip				___%	Percent
Name		Relationship		<input type="checkbox"/>	Primary
Address		DOB		<input type="checkbox"/>	Contingent
City, St, Zip				___%	Percent

Back-Up Withholding Certificate

I hereby certify under penalties of perjury that: The social security number shown on this form is my correct taxpayer identification number, I am a U.S. person (including a U.S. resident alien), and that (please check the appropriate box):

- I am not subject to withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service 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.
- I am subject to backup withholding.

This application, when signed by me and accepted by American Fidelity Health Services Administration - Administrator/Record keeper, constitutes my adoption of this application/Custodial Agreement. By signing this agreement, I acknowledge and certify that I have received either in print or electronically (available anytime at www.afhsa.com), read and agree to the terms in the HSA Custodial Agreement, HSA Interest & Fee Schedule and Terms and Conditions of my Account and any amendments thereof.

 Signature of Depositor

 Date

 Signature of Custodian

 Date