HEALTH SAVINGS CUSTODIAL ACCOUNT APPLICATION

County National Bank

INTERNAL USE ONLY: PORT NUMBER _____

ACCOUNT NUMBER _____ DATE OPENED _____

1) HSA Owner's Information

IMPORTANT ACCOUNT OPENING INFORMATION: Federal law requires us to obtain sufficient information to verify your identity. You may be asked several questions and to provide one or more forms of identification to fulfill this requirement. In some instances we may use outside sources to confirm the information. The information you provide is protected by our privacy policy and federal law.

FIRST NAME | **MI** | **LAST NAME**

TAXPAYER I.D. # ___ - ___ - ____ | **DATE OF BIRTH** __ - __ - ____ | **MOTHER'S MAIDEN NAME**

HOME PHONE # ___ - ___ - ____ | **WORK PHONE #** ___ - ___ - ____ | **CELL PHONE #** ___ - ___ - ____

PHYSICAL STREET ADDRESS

CITY | **STATE** | **ZIP** _____ - ____

ALTERNATE P.O. BOX MAILING ADDRESS (optional)

P.O. BOX | **CITY** | **STATE** | **ZIP** _____ - ____

FORM OF IDENTIFICATION (select one)

☐ **Driver's License** ☐ **State ID** ☐ **Passport** ☐ **Other:**

ISSUED BY | **ID NUMBER**

ISSUE DATE __ - __ - ____ | **EXPIRATION DATE** __ - __ - ____

EMPLOYER

OCCUPATION

E-MAIL ADDRESS

2) Taxpayer Identification Certification

Under penalties of perjury, I certify:

1) The number shown on this form is my correct taxpayer identification number; and
2) I am not subject to backup withholding either because: a) I am exempt from backup withholding, or b) I have not been notified by the 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.

Form W-9 instructions are available upon request.

The IRS does not require your consent to any provisions of this document other than the certifications required to avoid backup withholding.

_____

Signature of HSA Owner Date

INTERNAL USE ONLY: PORT NUMBER_____ ACCOUNT NUMBER _____

3) Authorized Signer / Power of Attorney (POA)

Since regulations require that only one individual can own a HSA account, the account owner may want his/her spouse or another third party through Power of Attorney ("POA") to write checks and/or use a debit card. Please complete the section below if you wish to grant power of attorney and/or issue a Debit MasterCard to your spouse or third party. I (accountholder) hereby designate the following individual as an additional authorized signer on my Health Savings Account. By requesting a POA on my account I authorize the following: My POA may conduct any financial transaction on my account including, but not limited to, making deposits and withdrawals, writing checks, negotiating or endorsing any checks or other instruments with respect to the referenced amount and obtaining bank statements. I (accountholder) understand that I assume full responsibility for how this individual ("POA") utilizes my HSA.

The financial institution is not responsible for monitoring the acts of the named power of attorney and will consider the power of attorney in effect unless I (accountholder) revoke it in writing, or the institution receives written notice of the death of the account owner. Furthermore, I (accountholder) agree to hold Hillsdale County National Bank harmless from any liability, including attorneys' fees and legal expenses incurred by the bank in acting in reliance upon this agreement.

FIRST NAME **MI** **LAST NAME**

TAXPAYER I.D. # **DATE OF BIRTH** **HOME/CELL PHONE #**

PHYSICAL STREET ADDRESS **P.O. BOX**

CITY **STATE** **ZIP**

☐ **I would like a second FREE debit MasterCard issued, for the POA listed above.**

MOTHER'S MAIDEN NAME

_____
Signature of Authorized Signer/POA (**not accountholder**) Date

4) Designation of Beneficiary

At the time of my death, the primary beneficiaries named below will receive my HSA assets. If all of my primary 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. If the percentage total for each beneficiary classification does not equal 100 percent, any remaining percentage will be divided equally among the beneficiaries within such class. This designation revokes all earlier beneficiary designations which may apply to this HSA.

Name and Address of Individual	Date of Birth	Taxpayer I.D. #	Relationship	Primary or Contingent	Percentage
				☐ Primary ☐ Contingent	%
				☐ Primary ☐ Contingent	%
				☐ Primary ☐ Contingent	%
				☐ Primary ☐ Contingent	%

Spousal Consent

_____ **I AM MARRIED.** I understand that if I designate a primary beneficiary other than my spouse, my spouse must consent by signing below.
Initial

_____ **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.
Initial

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 the HSA owner such interest in the assets held in the HSA and consent to the beneficiary designation set forth in this section of the form.

_____
Signature of Spouse Date

NOTE: Spouse's Signature is **only** required if you want to designate a primary death beneficiary other than your spouse.

INTERNAL USE ONLY: PORT NUMBER_____ ACCOUNT NUMBER _____

5) Account Options

☐ **I would like to order a box of 100 checks at a cost of $14.25.**

☐ **I would like 1 free debit MasterCard issued in my name for my account.**

☐ **I would like to sign up for Online Banking, which is a free option.**

6) HSA Eligibility Requirements

The effective date of my qualified High Deductible Health Plan (HDHP) is _____.
MM/DD/YYYY

I am or will be covered under a ☐ single or a ☐ family plan. (select one) The HDHP will have a deductible of $_____ .

_____ **I certify that I am not enrolled in Medicare.**
Initial

_____ **I certify that I am not covered by another health plan, other than a HDHP.**
Initial

_____ **I certify that I may not be claimed as a dependent on another person's tax return.**
Initial

7) Required Signature

By signing below, I acknowledge that:

- I wish to establish a Health Savings Account (HSA) with Hillsdale County National Bank as Custodian.
- I understand the eligibility requirements for deposits made to my Health Savings Account (HSA) and state that I qualify to make deposits to this account. I have reviewed the application, the Truth in Savings disclosure, HSA custodial account agreement (IRS form 5305-C), and the Funds Availability disclosure. I understand and agree to be bound by the terms and conditions that apply to this HSA as outlined in these documents.
- I authorize Hillsdale County National Bank to provide information about my HSA, including my account number, to my employer (if applicable) and those acting on behalf of my employer or Hillsdale County National Bank (if applicable), in connection with the establishment and maintenance of my HSA.
- I acknowledge that my employer and all others acting on behalf of my employer (if applicable), may provide information on my behalf to establish and maintain my HSA.
- I certify that the information provided in this application is true and complete.

_____ _____ _____
Signature of HSA Account Owner Date Signature of HSA Custodian (CNB Representative)

County National Bank
Banking that stays in the community

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