

Health Savings Account (HSA) Application Addendum

Opening Deposit (minimum \$30.00) **Payment enclosed with application**

ACCOUNT HOLDER INFORMATION: Please Print Clearly

Name _____ Social Security # _____ Date of Birth _____
Drivers License # _____ State of Issuance _____ Expiration Date _____
Date of Issue _____ Mothers Maiden Name/or Other Password _____

POWER OF ATTORNEY (POA) (OPTIONAL)

Since regulations require that only one individual owns the HSA Account, the account holder may want their spouse and/or another third party through Power of Attorney to write checks or use their Debit Card. I (account holder) hereby designate the following individual as additional authorized signer on my Health Savings Account.

Name _____ Social Security # _____ Date of Birth _____

BENEFICIARY(IES):

In the event of my death, I name as:

PRIMARY BENEFICIARY(IES) – Shares must equal 100%

Name _____
Relationship _____
Social Security Number _____
Mailing Address _____
City _____ State _____ Zip _____
Share (Percent of holding) _____%

Name _____
Relationship _____
Social Security Number _____
Mailing Address _____
City _____ State _____ Zip _____
Share (Percent of holding) _____%

SECONDARY BENEFICIARY(IES): - Shares must equal 100%

Name _____
Relationship _____
Social Security Number _____
Mailing Address _____
City _____ State _____ Zip _____
Share (Percent of holding) _____%

Name _____
Relationship _____
Social Security Number _____
Mailing Address _____
City _____ State _____ Zip _____
Share (Percent of holding) _____%

The above designations are subject to the Conditions of Beneficiary Designation listed below.

1. This designation is subject to all the terms and provisions of the agreement and shall be effective only if received by the trustee prior to the death of the person executing it.
2. This designation applies to the account holder's entire interest, if any, in trust account assets remaining undistributed at the account holder's death.
3. Each payment shall be made pursuant to this designation: (a) shall be paid in equal shares to the primary beneficiaries who are living at the time of the account holder's death or (b) if no primary beneficiary is living at the time, such payment shall be made in equal shares to the contingent beneficiaries who are then living at the time of the account holder's death.
4. This designation may be changed only by filing a written Change of Beneficiary Designation with the trustee.

Spousal Consent: To be completed if your spouse is not listed as your primary beneficiary. This section should be reviewed if either the trust of the residence of the HSA holder is located in a community or martial property state and the HSA holder is married. Due to important tax consequences of giving up one's community property interest, individuals signing this section should consult with a competent or legal tax advisor:

CURRENT MARTIAL STATUS

I am not married – I understand that if I become married in the future, I must complete a new HSA Designation of Beneficiary form.

I am married – I understand that if I chose to designate a primary beneficiary other than my spouse, my spouse must sign below.

I am the spouse of the above named HSA holder. I acknowledge that I have received a fair and reasonable disclosure of my spouse's property and financial obligations. Due to the important tax consequences of giving up my interest in this HSA, I have been advised to see a tax professional. I hereby give the HSA holder any interest I have in the funds or property deposited in this HSA and consent to the beneficiary designation indicated above. I assume full responsibility for any adverse consequences that my result. The Custodian gave no tax or legal advice to me.

Spouse – Signature Required	Date	Notary – Signature Required	Date
	/ /		/ /

ACCEPTANCE OF TERMS:

By my signature below I apply, and the institution by its signature accepts my application to establish a Health Savings Account pursuant to the terms of the Health Savings Account Agreement and Disclosure Statement (available at www.ahvthebancorp.com), which is incorporated into this application by reference. I authorize the bank to provide American Health Value all data necessary to maintain the account.

The account holder is responsible for the establishment and maintenance of this account pursuant to Federal guidelines. American Health Value is here to assist the account holder in accomplishing this.

HEALTH SAVINGS ACCOUNT TRUST AGREEMENT:

I acknowledge that I reviewed the Health Savings Account Trust disclosure statement (available at www.ahvthebancorp.com). The trustee or administrator is authorized to act without further inquiry in accordance with writings bearing my signature. I understand that I may revoke the agreement by written notice to the trustee or administrator within seven (7) days after the date of the agreement as specified below.

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.

This deposit account is subject to all applicable rules and regulations adopted by The Bancorp Bank. My signature acknowledges my acceptance of the Truth in Savings Disclosure governing these accounts. The Bancorp Bank may order a consumer report from a credit-reporting agency in order to evaluate whether to issue a Debit Card for those consumers who have applied. The Truth in Savings Disclosure is available at www.ahvthebancorp.com.

Primary Applicant – Signature Required	Date	Power of Attorney – Signature Required	Date
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Under penalties of perjury, I certify that: 1. the number shown on this form is my correct taxpayer identification number (TIN) (or I am waiting for a number to be issued to me), and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding under Internal Revenue Service (IRS) regulations, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the Internal Revenue Service 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 Internal Revenue Service that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return.

THE INTERNAL REVENUE SERVICE DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE CERTIFICATION REQUIRED TO AVOID BACKUP WITHOLDING.

Primary Applicant – Signature Required	Date	Power of Attorney – Signature Required	Date
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The Bancorp Bank

Trustee under the agreement, hereby acknowledges receipt of the above application and successor designation.

By Authorized Officer

<u>For Administrative Use Only</u>	
Date Account Opened:	_____
Account Number:	_____
Plan Number:	_____