Health Savings Account Application

Heritage BANK

Today's Date: _____ / _____ / 20____

Clear Form

A Health Savings Account (HSA) is a form of consumer directed health coverage pairing a qualified high deductible health plan with a tax–free savings account. HSAs were designed to reduce healthcare insurance costs for both employers and employees. The high deductible policy provides protection against major medical expenses and the HSA is used to pay for the day-to-day medical expenses.

Please print clearly and complete all applicable sections of this application. (* Required Fields)

Member FDIC

Health Savings Account Owner Information

Legal Name*	**Social Security Number***	**Date of Birth***	**Mother's Maiden Name***
Physical Address*	**City***	**State***	**Zip Code***
Mailing Address*	**City***	**State***	**Zip Code***
Driver's License Number* **State of Issuance*** **Issue Date*** **Expiration Date***	**Home Phone Number***	**Cell Phone Number***	**Work Phone Number***
Gender: ☐ Male ☐ Female ☐ Prefer not to say **Marital Status:*** ☐ Married ☐ Unmarried	**Email Address** (optional)		
Employer*	**Position***		
Type of Health Insurance Plan Coverage* (choose one): ☐ Self–Only ☐ Family	**Would you like checks ordered?** ☐ Yes ☐ No	**Date of HDHP Opened** _____ / _____ / _____	

Power of Attorney (Optional)

Complete the section below if you wish to designate an attorney in fact for your Health Savings Account. If you do not wish to designate an attorney in fact, you may leave this section blank and continue to the next step. Since regulations require that only one individual own a Health Savings Account, the accountholder may want his/her spouse and/or another third party through power of attorney to write checks and/or obtain a debit card. I (accountholder) hereby designate the following individual as additional attorney in fact on my Health Savings Account.

Legal Name*	**Social Security Number***	**Date of Birth***	**Mother's Maiden Name***
Physical Address*	**City***	**State***	**Zip Code***
Mailing Address*	**City***	**State***	**Zip Code***
Driver's License Number* **State of Issuance*** **Issue Date*** **Expiration Date***	**Home Phone Number***	**Work Phone Number***	
Employer*	**Position***	**Order a Debit Card** ☐ Yes ☐ No	

Health Savings Account Agreement

The undersigned certifies the accuracy of the information he/she has provided and acknowledges by returning this application a Health Savings Account will be opened in his/her name at Heritage Bank. The undersigned also acknowledges the signature card agreement and additional disclosures will be mailed to the address provided upon funding of the account.

Owner Signature: _____ **Date:** _____

POA Signature: _____ **Date:** _____

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Contribution Information (Complete this section if sending funds with application.)

Contribution Amount $	**Contribution Tax Year** ☐ Current Year ☐ Prior Year
Contribution Type (select one): ☐ Regular ☐ Rollover from a Health Savings Account ☐ Rollover from an Archer Medical Savings Account ☐ Catch–Up (age 55 or older and not enrolled in Medicare) ☐ Transfer from a Health Savings Account ☐ Transfer from an Archer Medical Savings Account	**Contribution Information (select one):** ☐ HSA Owner ☐ Employer ☐ Family Member ☐ Other (specify) _____
Automated Monthly Contributions (from Heritage Bank checking) Account # to debit: _____	**Contribution Direct Deposit Date** ☐ 15th of every month **OR** ☐ 30th of every month

Designation of Beneficiary

At the time of my death, the primary beneficiaries named below will receive my HSA assets. If all 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 and supersedes all earlier beneficiary designations, which may apply to this HSA.

A. Primary Beneficiary (* Required Fields)

Legal Name *	**Date of Birth ***	**SSN or Taxpayer ID Number**	**Relationship**	**Percentage %**
Physical Address	**City**	**State**	**Zip Code**	
Mailing Address	**City**	**State**	**Zip Code**	
Legal Name *	**Date of Birth ***	**SSN or Taxpayer ID Number**	**Relationship**	**Percentage %**
Physical Address	**City**	**State**	**Zip Code**	
Mailing Address	**City**	**State**	**Zip Code**	

B. Contingent Beneficiary (* Required Fields)

Legal Name *	**Date of Birth ***	**SSN or Taxpayer ID Number**	**Relationship**	**Percentage %**
Physical Address	**City**	**State**	**Zip Code**	
Mailing Address	**City**	**State**	**Zip Code**	
Legal Name *	**Date of Birth ***	**SSN or Taxpayer ID Number**	**Relationship**	**Percentage %**
Physical Address	**City**	**State**	**Zip Code**	
Mailing Address	**City**	**State**	**Zip Code**	

Branch Representative: _____ **Branch:** _____ **Phone Number:** _____