

# HSA APPLICATION AND AGREEMENT

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A \$14.99 processing fee will be charged for all paper applications received. **Free online enrollment available at HSA.towerbank.net.**

**A**

## ACCOUNT HOLDER

Name (first) (middle) (last)			Social Security #		Date of Birth (xx-xx-xxx format)	
Street Address (cannot be P.O. Box)			City		State	Zip Code
Mailing Address (if different from Street Address)			City		State	Zip Code
Home Phone			Business Phone			
E-mail Address			Mother's Maiden Name or Password			
Type of Identification			Identification Number			
Issuing State or Entity			Date Issued		Expiration Date	
Contribution Year	Type of Contribution:		<input type="checkbox"/> New	<input type="checkbox"/> Rollover from IRA (attach rollover form)		
			<input type="checkbox"/> Transfer from HSA (attach transfer form)	<input type="checkbox"/> Rollover from MSA (attach rollover form)		

The Patriot Act: 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 to you: When you open an account we will ask you for your name, street address, date of birth, and other information that will allow us to identify you. We may ask to see your driver's license and other identifying documents.

**B**

## DESIGNATION OF BENEFICIARIES

The following individual (s) or entity shall be my primary and/or contingent beneficiary (ies). If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary beneficiary. If more than one primary beneficiary is designated and no distribution percentages are indicated, the beneficiaries will be deemed to own equal share percentages in the account. Multiple contingent beneficiaries with no share percentage indicated will also be deemed to share equally. If primary or contingent beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining beneficiary (ies) shall be increased on a pro-rated basis. If no primary beneficiary (ies) survive me, the contingent beneficiary (ies) shall acquire the designated share of my account. No tax or legal advice was given to me by the custodian or agent; I assume full responsibility for any adverse consequences.

Name and Address	Date of Birth	Social Security #	Relationship	Primary or Contingent	Share %
				Primary <input type="checkbox"/> Contingent <input type="checkbox"/>	
				Primary <input type="checkbox"/> Contingent <input type="checkbox"/>	
				Primary <input type="checkbox"/> Contingent <input type="checkbox"/>	

**C**

## HEALTH PLAN INFORMATION

Choose One: <input type="checkbox"/> \$ _____ individual health plan annual deductible <input type="checkbox"/> \$ _____ family health plan annual deductible					
Health Insurance Company		Section 125 plan - Pre-Tax? Yes <input type="checkbox"/> No <input type="checkbox"/>		Effective Date	
		(check one)			
Insurance Agent		Insurance Agency		Agent Phone Number	

**D**

## HSA ACCOUNT OPTIONS

(Choose One:)  Online Statement  Paper Statement

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## ADDITIONAL AUTHORIZED SIGNER (OPTIONAL)

Printed Name (first)	(middle)	(last)	Social Security #
Date of Birth (xx-xx-xxxx format)		Mother's Maiden Name or Password	

## OTHER OPTIONS

- I would like to order 50 duplicate checks to be used for normal distributions only. Quoted fees apply.
- I would like to order a free Visa Debit Card issued in my name for this HSA to be used for normal distribution only. (If you have elected for an additional authorized signer, a second free debit card will automatically be issued.)

Note: Online Banking access is automatically available for all accounts. Please be sure to include your e-mail address in section A.

## EMPLOYEE VERIFICATION

<b>Group Enrollment.</b> To comply with the USA Patriot Act of 2001, the employer must verify the employee's identification and social security number.			
Company Name			
Address	City	State	Zip Code
As a representative of this company, I verify the Health Savings Account holder named in section A is an active employee and his/her social security number is valid.			
Signature X _____			
Contact Person	Phone	E-mail	

## HEALTH SAVINGS ACCOUNT ADOPTION AGREEMENT

This application, when signed by me and accepted by Tower Bank as Custodian, constitutes my adoption of the Tower Bank Health Savings Account Custodial Agreement and my acceptance of the terms thereof.

By signing this Application, I acknowledge:

1. That my HSA has been established for the purpose of paying qualified medical expenses, and if distributions are not used for this purpose, I may be subject to ordinary income and penalty taxes, which I must report to the IRS.
2. That no loans may be taken from my HSA and no portion of my HSA may be used as security or collateral for a loan.
3. I am responsible for my HSA activity and Tower Bank has no duty to determine the investment tax, or other consequences resulting from my actions involving my HSA.
4. I will receive a copy of the HSA Custodial Agreement and Disclosure Statement in my enrollment packet.
5. All fees are non-refundable.
6. If I have listed an additional authorized signer on Page 2, I hereby designate this person as an additional signer on my Health Savings Account to sign checks or otherwise transact business on this account.

## BACK-UP WITHHOLDING CERTIFICATE

By signing below I certify that under the penalties of perjury:

1. The number shown on this form is my correct taxpayer identification number.
2. I am not subject to backup withholding either because I have not been notified that I am subject to backup withholding as a result of failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding. The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.
3. I am a U.S. person (including a U.S. resident alien).

## ELIGIBILITY REQUIREMENTS - ACCOUNT HOLDER

- Yes I certify that: (1) I am covered by a qualified High Deductible Health Plan (HDHP), (2) I certify that I am not covered by a health plan, other than HDHP, which provides any of the same benefits as the HDHP, (3) I am not entitled to benefits under Medicare, and (4) I am not claimed as a dependent on another person's tax return, or (5) I or my spouse was previously covered under an HDHP and the funds deposited will be a transfer or rollover of those existing HSA funds.
- No

Account Holder's Signature X \_\_\_\_\_ Date \_\_\_\_\_