

## Health Savings Account Application and Custodial Agreement

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? (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 health plan? (See <a href="http://www.afhsa.com">www.afhsa.com</a> 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				
<del>Initial Contribution - \$50 minimum is required with the application. After the establishment of your HSA, an account set up fee of \$10.00 will be applied to your account.*</del>	\$	**	Is this a rollover contribution?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			Is this a transfer?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
For which tax year? <span style="font-size: 1.2em; color: blue;">2013</span>			(If yes to either of the questions above, please complete & attach the Rollover/Transfer Form)	
Contribution	Annual	Per Pay Period	Pay Period (if applicable)	* The set up fee can be submitted with your initial deposit or can be deducted from the first deposit to your account. (If you signed up for the HSA through your employer, this fee may not apply.) ** Deposits may not be available for immediate withdrawal until confirmation by your financial institution is received.  To determine maximum annual contribution visit <a href="http://www.afhsa.com">www.afhsa.com</a> . Accountowners age 55+ can make additional contributions of \$1,000/year.
Employer	\$	\$	<input checked="" type="checkbox"/> Monthly	
Individual	\$	\$	<input type="checkbox"/> Bi-monthly	
Catch-up Contribution	\$	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly	

2 cards at no cost!

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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
*Dependent must be 18 yrs or older.			
Name		Relationship	
Social Security #		DOB (mm/dd/yyyy)	
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, the custodial agreement and all applicable regulations that apply govern the secondary card.			

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):
<input checked="" type="checkbox"/> 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.
<input type="checkbox"/> 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](http://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 (Am. Fidelity)	_____ Date
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