

HEALTH SAVINGS ACCOUNT APPLICATION



Contact Information

Last Name _____ First Name _____ MI _____
SSN _____ Date of Birth _____ HDHP Coverage Self Family
Street Address _____ City _____ State _____ ZIP _____
Email Address _____ Home Phone _____ Business Phone _____

Contribution Information

Contribution Date _____ Contribution Amount _____ Tax Year _____ Employer Name _____
Contribution Type Regular Rollover Transfer

The following individual(s) will be my Primary and or Contingent Beneficiary (ies).

If any primary or contingent beneficiary dies before I do, 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 increase on a pro-rata basis.

Primary Beneficiary Information

Name of Beneficiary _____
Date of Birth _____ SSN _____ Relationship _____ Percent _____
Name of Beneficiary _____
Date of Birth _____ SSN _____ Relationship _____ Percent _____
Total 100% _____

Contingent Beneficiary Information

Name of Beneficiary _____
Date of Birth _____ SSN _____ Relationship _____ Percent _____
Name of Beneficiary _____
Date of Birth _____ SSN _____ Relationship _____ Percent _____
Total 100% _____

Spousal Consent

- I am not married. I understand that if I marry in the future, I must complete a new Designation of Beneficiary Form.
- I am married. I understand that if I designate a beneficiary other than my spouse, my spouse must consent by signing below.

I am the spouse of the above-named HSA account 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 account owner any interest I have in the funds or property deposited into this HSA and consent to the beneficiary designation indicated above. I assume full responsibility for any adverse consequences that may result. I understand that I may revoke this HSA on or before 7 days after the date of establishment. No tax or legal advice was given to me by the custodian.

Signature of Spouse Date Signature of Witness Date

The USA Patriot Act of 2001

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 is that we will ask for your name, address, date of birth and other information that will allow us to identify you and any authorized signer. If your identity cannot be authenticated, or your application is incomplete, we will not open the account.

Please complete the following information as a part of your application.

Drivers License Number _____ State _____
Issue Date _____ Expiration Date _____ Mother's Maiden Name _____
Employer Name _____
Employer City _____ Employer State _____ Employer Phone _____

Authorized Signer

By regulation, an HSA is an individual account owned by the account holder. You may designate an Authorized signer to write checks or use your HSA Check Card. If so, please complete the following:

Last Name _____ First Name _____ MI _____
SSN _____ Date of Birth _____
Street Address _____ City _____ State _____ ZIP _____
Email Address _____ Home Phone _____ Business Phone _____
Drivers License Number _____ State _____
Issue Date _____ Expiration Date _____ Mother's Maiden Name _____
Employer Name _____
Employer City _____ Employer State _____ Employer Phone _____

You hereby designate the above individual as an Authorized Signer on your Health Savings Account (HSA). By designating an Authorized Signer on your account, you authorize the person designated above as "Authorized Signer" to make deposits or withdrawals by any means acceptable to 1st Source Bank, including paper and electronic transactions; receive and have access to account information, including account balances and transactions; endorse any instruments such as checks, orders or other documents for the payment of funds. You understand that you are responsible for ensuring that your Authorized Signer reads and understands terms and conditions disclosures which have been provided to you. You hold harmless and indemnify 1st Source Bank against any claims or losses 1st Source Bank may suffer arising out of reliance on this authorization, and release 1st Source Bank from any liability arising from such reliance unless otherwise prohibited by law. You understand that you bear sole responsibility for any tax consequences that result from any action taken by the Authorized Signer regarding your account.

**No present or future ownership or right of survivorship is given to the Authorized Signer by this authorization. Upon notice to 1st Source Bank of your death, this authorization terminates and rights to funds in your account will be transferred to your beneficiaries. If you did not name a beneficiary, your account balance will only be payable to your estate.*

Options

Your 1st Source HSA account includes one FREE HSA Check Card. You may choose to add the following options:

- One box of HSA checks at current check price
- FREE additional HSA check card (Authorized Signer)

