



County National Bank

HEALTH SAVING ACCOUNT APPLICATION

INTERNAL USE ONLY:

PORT NUMBER

ACCOUNT NUMBER

DATE OPENED

 ATM F/M IMAGE

1) HSA Owner's Information

FIRST NAME

MI

LAST NAME

SOCIAL SECURITY #

DATE OF BIRTH

HOME OR CELL PHONE #

WORK PHONE #

PHYSICAL STREET ADDRESS

CITY

STATE

ZIP

ALTERNATE P.O. BOX MAILING ADDRESS (OPTIONAL)

P.O. BOX

P.O. BOX CITY

P.O. BOX STATE

P.O. BOX ZIP

FORM OF IDENTIFICATION

(select one)

Driver's License

STATE

State ID

STATE

Passport

ID NUMBER

EXPIRATION DATE

EMPLOYER NAME

OCCUPATION

2) Taxpayer Identification Certification

Under penalties of perjury, I certify:

- The Social Security Number shown on this form is my correct taxpayer identification number.
- 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 IRS has notified the Client that the Client is no longer subject to backup withholding.
- I am a U.S. person (including a U.S. resident alien).

Signature of HSA Account Owner

Date

3) Designation of Beneficiary

At the time of my death, the primary beneficiaries named below will receive my HSA assets. If all of my primary beneficiaries die before me, the contingent beneficiaries named below will receive my HSAs 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 all earlier beneficiary designations which may apply to this HSA.

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

Spousal Consent

CURRENT MARITAL STATUS

I AM MARRIED. I understand that if I designate a primary beneficiary other than my spouse, my spouse must consent by signing below.
 initial _____

I AM NOT MARRIED. I understand that if I marry in the future, I must complete a new Designation of Beneficiary form, which includes the spousal consent documentation.
 initial _____

I am the spouse of the HSAs owner. Because of the significant consequences associated with giving up my interest in the HSAs, the custodian has not provided me with legal or tax advice, but has advised me to seek tax or legal advice. I acknowledge that I have received a fair and reasonable disclosure of the HSAs owner's assets or property, including any financial obligations for a community property state. In the event I have a legal interest in the HSAs assets, I hereby give to the HSAs owner such interest in the assets held in the HSAs and consent to the beneficiary designation set forth in this section of the form.

Signature of Spouse _____ Date _____ **NOTE:** Spouse's Signature is **only** required if you want to designate a primary death beneficiary other than your spouse.

4) Account Options

I would like to order a box of 50 checks at a cost of \$10.25.

I would like 1 free debit MasterCard issued in my name for my account.

I would like to sign up for Online Banking, which is a free option.

Mother's maiden name _____ . Email address _____ .

5) HSA Eligibility Requirements

The effective date of my qualified High Deductible Health Plan (HDHP) is _____ .
 MM/DD/YYYY

I am or will be covered under a single or a family plan. SELECT ONE The HDHP will have a deductible of \$ _____ .

initial _____ I certify that I am not enrolled in Medicare.

initial _____ I certify that I am not covered by another health plan, other than a HDHP.

initial _____ I certify that I may not be claimed as a dependent on another person's tax return.

Federal law requires us to obtain sufficient information to verify your identity. You may be asked several questions and to provide one or more forms of identification to fulfill this requirement. In some instances we may use outside sources to confirm the information. The information you provide is protected by our privacy policy and federal law.

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6) Authorized Signer / Power of Attorney (POA)

Since regulations require that only one individual can own an HSA account, the account owner may want his/her spouse and/or another third party through Power of Attorney ("POA") to write checks and/or use a debit card. Please complete the section below if you wish to grant power of attorney and issue a Debit MasterCard to your spouse. I (accountholder) hereby designate the following individual as additional authorized signer on my Health Savings Account. By requesting a POA on my account I agree to the following: My POA may conduct any financial transaction on my account listed above including, but not limited to, making deposits and withdrawals, writing checks, internet access to the account, negotiating or endorsing any checks or other instruments with respect to the referenced amount, obtaining bank statements, drafts money orders, warrants and certificates or vouchers payable to me by any person, firm, corporation or political entity. I (accountholder) understand that I assume sole responsibility for how this individual ("POA") utilizes my HSA.

The financial institution is not responsible for monitoring the acts of the named power of attorney and will consider the power of attorney in effect unless I (accountholder) revoke it in writing, or the institution receives written notice of the death of the account owner. Furthermore, I (accountholder) agree to hold County National Bank harmless from any liability, including attorneys' fees and legal expenses incurred by the bank in acting in reliance upon this agreement.

FIRST NAME	MI	LAST NAME
<input type="text"/>	<input type="text"/>	<input type="text"/>

SOCIAL SECURITY #	DATE OF BIRTH
<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

PHYSICAL STREET ADDRESS

CITY	PO BOX
<input type="text"/>	<input type="text"/>

STATE	ZIP
<input type="text"/>	<input type="text"/> - <input type="text"/>

HOME OR CELL PHONE #

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Second Debit Card Option

Signature of Authorized Signer/POA (NOT ACCOUNTHOLDER) _____ Date _____

I would like a second FREE debit MasterCard issued, for the POA listed above, for my account to be used for normal distributions only.

IMPORTANT ACCOUNT OPENING INFORMATION: Federal law requires us to obtain sufficient information to verify your identity. You may be asked several questions and to provide one or more forms of identification to fulfill this requirement. In some instances we may use outside sources to confirm the information. The information you provide is protected by our privacy policy and federal law.

7) Required Signature

By signing below, I acknowledge that:

- I wish to establish a Health Savings Account (HSA) with County National Bank as Custodian.
- I understand the eligibility requirements for deposits made to my Health Savings Account (HSA) and state that I qualify to make deposits to this account. I have reviewed the application, the Truth in Savings disclosure, HSA custodial account agreement (IRS form 5305-C), and the Funds Availability disclosure. I understand and agree to be bound by the terms and conditions that apply to this HSA as outlined in these documents.
- I authorize County National Bank to provide information about my HSA, including my account number, to my employer (if applicable) and those acting on behalf of my employer or County National Bank (if applicable), in connection with the establishment and maintenance of my HSA.
- I acknowledge that my employer and all others acting on behalf of my employer (if applicable), may provide information on my behalf to establish and maintain my HSA.
- I certify that the information provided in this application is true and complete.

Signature of HSA Account Owner _____

Date _____

Signature of HSA Custodian (CNB Representative) _____



www.CountyNationalBank.com
1-888-322-1088

