

Want to apply for your HSA online? Go to <https://www.americanchartered.com/HSAchecking.aspx>

Employer Group HSA Applications: Forward your application as directed by your benefits/ human resources department.

Individual applicants, mail your completed application to:
 American Chartered Bank
 HSA Processing
 PO Box 5994
 Carol Stream, IL 60197-5994

Important Information about Opening an 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 a copy of your driver's license, social security card or other identifying documents.

Eligibility Requirements (Required)

Answer the following four questions to determine if you are eligible for a Health Savings Account (HSA).*

1. I am covered under a Qualified High Deductible Health Plan (QHDHP).
 YES NO
2. I am not covered by a health plan, other than a QHDHP, which provides any of the same benefits as the QHDHP.
 YES NO
3. I am not eligible for Medicare (age 65) or if I am eligible, I am not enrolled in Part A or B. YES NO
4. I am not dependent on another person's tax return.
 YES NO

If you answered NO to any of the four questions above DO NOT CONTINUE. You are NOT eligible to open a Health Savings Account. By signing and submitting this application you affirm your eligibility to establish a Health Savings Account.

*You may still be eligible to open an HSA if you are transferring HSA funds from another custodian even if you answered NO to any of the four questions above. We recommend you check with your tax advisor before making further contributions.

Personal Information (REQUIRED) PLEASE PRINT CLEARLY

Name _____
(FIRST) (INITIAL) (LAST)

Social Security Number _____ Birth Date _____

Residence Street Address _____

U.S. Patriot Act regulations require that we obtain a valid street address from all new customers. If you use a P.O. Box for mailing purposes, you must also provide us with a valid street address for verification purposes. In an effort to avoid additional address verification follow up, you may include a copy of an unexpired drivers license, utility bill or current pay stub showing the street address entered on your application.

Alternate Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Business Phone _____

Form of Identification: ID Number _____ Driver's License State ID Passport

ID State of Issue _____ ID Issue Date _____ ID Expiration Date _____

City and State of Birth _____ Mother's Maiden Name _____

Email Address (Required for Online Banking and eStatements) _____

Account Type/Opening Deposit (REQUIRED)

Type of account desired. (If no choice is made the default will be HSA Checking):

- HSA Checking
- HSA Certificate of Deposit
 (CD Term: _____)

HDHP insurance coverage (Choose one):

- Individual Coverage
- Family Coverage

Deposit Type:

- Regular – Contribution Year: _____
- Custodian to Custodian Transfer*

*Attach Transfer Form

Additional Health Savings Account Product & Service Options

- I would like to order personalized checks for my HSA Account. Please include a separate check made payable to American Chartered Bank for the check-printing fee of \$17.20 for single checks or \$19.20 for duplicate checks. **(Checks are not offered with HSA Certificates of Deposit)**
- I would like a free Visa® Debit Card* issued in my name. **(Visa Debit Cards are not offered with HSA Certificates of Deposit)**

Online Banking: To enroll in Online Banking visit the bank's web site at www.americanchartered.com and click on 'ENROLL IN ONLINE BANKING' found on the Online Banking section of the home page. To enroll you will need your account number which will arrive in your welcome packet.

Electronic Statements: Your HSA will automatically be set up with Electronic Statements (E-Statements). American Chartered Bank will assign your E-Statement password. **Your password will be the first five (5) characters of the e-mail address you have provided to us plus the last four (4) digits of your social security number.** No thanks. Please mail my statement.

* Please Note: Purchases made with either a Visa Debit Card or checks will be reported by the Bank as "normal distributions" for the year in which the transaction is posted to the account. You should not use your Visa Debit Card or checks for non-qualifying or non-medical purposes. You may be subject to IRS penalties if you do. We ask that you submit an HSA withdrawal form when requesting a non-qualifying or non-medical distribution. This form is available on our website at <https://www.americanchartered.com/personalHealthSavings.aspx>.

AMERICAN CHARTERED BANK HEALTH SAVINGS ACCOUNT APPLICATION (Page 2 of 3)

Designation of Authorized Signer (Not required & not applicable on CDs)

If you wish to grant your spouse or a third party access to your account as an Authorized Signer please complete all the required fields below and have the Authorized Signer sign the signature card where indicated.

NAME (FIRST)	(INITIAL)	(LAST)
ADDRESS		
SOCIAL SECURITY NUMBER	BIRTH DATE	
Form of Identification: <input type="checkbox"/> Driver's License <input type="checkbox"/> State ID <input type="checkbox"/> Passport		
ID NUMBER		
ID STATE OF ISSUE	ID ISSUE DATE	ID EXPIRATION DATE
CITY OF BIRTH	STATE OF BIRTH	MOTHER'S MAIDEN NAME

I authorize American Chartered Bank to issue an additional Visa Debit Card on my account to the authorized signer designated above. If more than one person signs this application, all such persons agree to be jointly and severally liable for the performance of the obligations set forth in the Visa Debit Card Agreement, to be sent with the cards. I acknowledge I will be liable for the use of the Visa Debit Card by the authorized signer. Limit 2 free debit cards per account. Your HSA will be charged \$5 for each additional card issued.

Employer Information

EMPLOYER NAME		
EMPLOYER CONTACT NAME		
EMPLOYER CONTACT NUMBER	ADDRESS	
CITY	STATE	ZIP CODE

Designation of Beneficiaries

The following individual(s) or entity shall be my primary and/or contingent beneficiary(s). 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 a 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(s) shall be increased on a pro-rated basis. If no primary beneficiary(s) survives me, the contingent beneficiary(s) shall acquire the designated share of my account.

Beneficiary Name and Address	Date of Birth	Relationship	Primary or Contingent	Share (Percent)
			<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	
			<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	

Rules and Regulations

By signing the attached signature card I hereby appointed American Chartered Bank to serve as custodian of my Health Savings Account. I also understand and agree to be bound by the rules and regulations which apply to Health Savings Accounts as established by this Application, the HSA Custodial Agreement and any amendments made to them from time to time. I also agree to be bound by the Bank's rules, regulations, agreements and disclosures applicable to this account and any additional accounts that I establish with the Bank in the future. I understand the eligibility requirements for the type of HSA deposit that I am making, and I state that I do qualify to make the deposit. The HSA Custodial Agreement and all account disclosures will be provided at account opening. If this account is opened electronically or through the mail these documents will be mailed to me no later than 10 business days after this account is opened.

Within seven (7) calendar days from the date I open this HSA, I may revoke it by mailing or delivering a written notice to the custodian of the account.

I assume complete responsibility for:

- (1) Determining that I am eligible for a HSA each year I make a contribution
- (2) Ensuring that all contributions I make are within the limits set forth by the tax laws
- (3) The tax consequences of any contribution (including rollover contributions) and distributions.

HEALTH SAVINGS ACCOUNT SIGNATURE CARD

HSA OWNER'S NAME Please Print	DATE	ONE NUMBER OF SIGNATURES REQUIRED (Bank Use Only)	ACCOUNT NUMBER (Bank Use Only)
HSA ACCOUNT OWNER'S ADDRESS – Please Print			
HSA ACCOUNT OWNER'S SIGNATURE (Required)		SOCIAL SECURITY NUMBER – HSA Account Owner	
AUTHORIZED SIGNER'S SIGNATURE (if applicable)		SOCIAL SECURITY NUMBER – Authorized Signer	

The depositor agrees to be bound by the rules and regulations regulating this account as described in the Custodial Agreement and account disclosures and by any amendments to them. The depositor has read and certifies under provision of perjury to the truthfulness of the tax withholding certificate appearing below. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding. Signatures shown above are specimen or facsimile signatures of person(s) authorized to effect transactions on this account by the current depository resolution that filed with the Bank. If Single Name Account: This account is owned by the party named hereon.

TAX WITHHOLDING CERTIFICATE: Under penalties of perjury, the depositor certifies (1) that the tax identification number shown on this form is the depositor's correct tax payer identification number and that (2) the depositor is not subject to backup withholding either because (a) the depositor is exempt from such withholding, (b) the depositor has not been notified that the depositor is subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the Internal Revenue Service has notified the depositor that the depositor is no longer subject to backup withholding. ****Strike part (2) of this paragraph if the depositor has been notified that the depositor is subject to backup withholding due to underreporting and has not received a notice from the Internal Revenue Service that backup withholding has terminated.**

By signing this card I acknowledge that I have read and agree to all the conditions contained in this HSA account application. I also authorize American Chartered Bank to release to my employer account related information necessary to support the posting of contributions to my Health Savings Account including account number, SSN, and bank routing information.

Spousal Consent

This section should be reviewed if the residence of the Account Holder is located in a community or marital property state, and the Account Holder is married. Due to important tax consequences of giving up one's community property interest, individual's signing below should consult with a competent legal or tax advisor.

- I am not married:** I understand that if I become married in the future, I must complete a new Designation of Beneficiary form.
- I am married:** I understand that if I choose to designate a primary beneficiary other than my spouse, my spouse must sign the spousal consent portion on the attached signature card and my spouse's signature must be witnessed by someone other than myself.

SPOUSAL CONSENT FORM

Complete this section ONLY if the HSA Account Owner is married and their spouse HAS NOT been designated as the primary beneficiary.

SIGNATURE OF SPOUSE*

SIGNATURE OF WITNESS:
(Cannot be HSA account holder or spouse)

* I am the spouse of the above-named 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 account, I have been advised to see a tax professional. I hereby give the Account Holder any interest I have in the funds or property deposited in this account, and consent to the beneficiary designation(s) indicated above. I assume full responsibility for any adverse consequences that may result. The Custodian gave no tax or legal advice to me.