HSA Establishment Application

Employer Name:

Please note: All fields are required. As a part of the U.S. Patriot Act of 2001, financial institutions must verify the identity of any person seeking to open an account. If the information provided in Section A cannot be verified via the ID verification process, we will contact you to obtain documentation to validate the accuracy of the information. HSA funds will be on hold until the ID verification hold has been cleared. If not cleared within 60 days of notice, your HSA will be closed and any funds returned to the originating account.

Accountholder Information:

Name:
First/Last

Social Security Number:

Date of Birth:
MM/DD/YYYY

Primary Phone:

Gender: ☐ M ☐ F

Home Address - Cannot be P.O. Box

Address: City: State: Zip Code:

Mailing Address - Can be P.O. Box

Address: City: State: Zip Code:

Date of Hire:
MM/DD/YYYY

Division:
(If Applicable)

Email Address:

Email is required to receive important account notifications such as claim confirmations, payment notifications and denial letters.

Medical Plan Information For the HSA-Qualified High Deductible Health Plan (HDHP):

HDHP Effective Date:
MM/DD/YYYY

HDHP Coverage Level: ☐ Individual ☐ Family

If HDHP Effective Date Is:	And HSA Application Signature Date Is:	The HSA Effective Date Can Be:
First of month Example: January 1	On or Prior to HDHP Effective Date Example: January 15	HDHP Effective Date or any later date Example: January 1 or later date
First of month Example: January 1	After HDHP Effective Date Example: January 15	Date of application or any later date Example : January 2 or later date
Other than First of month Example: January 15	On or 1st of month following HDHP Effective Date Example: January 25	1st of month following HDHP effective date or later Example: February 1 or later date
Other than First of month Example: January 15	After or 1st of month following HDHP Effective Date Example: February 2	Date of application or any later date Example: February 2 or later date

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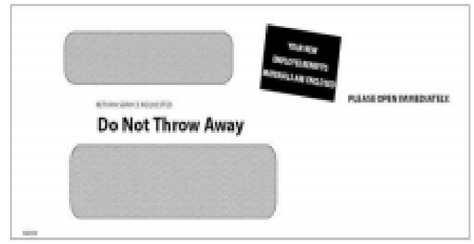
Debit Card:

You will automatically receive a set of two identical debit cards that you can use to access HSA funds when paying at the point of service/sale or when paying a bill. Debit cards will be mailed to your home address in an envelope that looks like this.

You will sign the back of one card and an eligible dependent can sign the back of the other card for his/her use. Additional and replacement cards can be ordered by contacting Benefit Strategies at 888-401-3539 or info@benstrat.com. Fee may apply.



Distribution Request:

You can request a distribution of funds from your HSA easily through your secure online account at www.benstrat.com. You can also complete and submit the HSA Distribution Form. The form can be downloaded from our website or you can contact Benefit Strategies to have the form sent to you. Indicate below how you would like to receive the funds when you request a distribution.

☐ **Direct Deposit** **No fee.**

☐ **Check** **$5.00 fee** applies for each check distribution.

Direct Deposit:

For faster reimbursement, sign up for direct deposit through our online portal or direct deposit form.

Beneficiary Designation:

I designate the following individual(s) or entity as my primary or contingent death beneficiary(ies) of this HSA, and I hereby revoke all prior death beneficiary designations made by me. Share percentages must equal 100% for primary and 100% for contingent.

Name: First/Last — Relationship: ☐ **Spouse** ☐ **Dependent** ☐ **Other**

Date of Birth: MM/DD/YYYY — Full SSN: ☐ **Primary** **OR** ☐ **Contingent**

Address: City, State, Zip — Share Percentage:

Name: First/Last — Relationship: ☐ **Spouse** ☐ **Dependent** ☐ **Other**

Date of Birth: MM/DD/YYYY — Full SSN: ☐ **Primary** **OR** ☐ **Contingent**

Address: City, State, Zip — Share Percentage:

Name: First/Last — Relationship: ☐ **Spouse** ☐ **Dependent** ☐ **Other**

Date of Birth: MM/DD/YYYY — Full SSN: ☐ **Primary** **OR** ☐ **Contingent**

Address: City, State, Zip — Share Percentage:

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Please check one of the following:

☐ I am not married. If I become married at a future date, I understand I must complete a new Beneficiary Designation form.

☐ I am married. I understand that if I choose to designate a primary beneficiary other than my spouse, he or she must agree to the designation by signing below. My spouse's signature must be notarized.

Notarized Signature of Spouse: Date:

First/Last MM/DD/YYYY

(Only required if spouse is waiving beneficiary rights)

Subscribed and sworn to before me this _____ day of _____ 20 ____ Notary Public: _____

Signature And Acknowledgments:

By executing this form:

- I acknowledge that I understand I will receive an HSA confirmation email from Benefit Strategies with account login instructions and I am then responsible for logging in to my account at www.benstrat.com accepting Terms and Conditions. I understand that until I do so, I will not have any access to contributions made to my HSA from any source.
- I acknowledge that I will read the HSA Disclosure Statement and HSA Custodial Agreement (including Privacy Policy) online at www.benstrat.com and agree to receive future notices of updates by visiting www.benstrat.com, and to review the Custodial Agreement (and Privacy Policy) no less frequently than annually. (Privacy Policy can also be viewed by visiting www.wexinc.com/solutions/benefits/)
- I understand that by opening an HSA I am consenting to receive electronic documents, including the monthly HSA Account Statement, and that if I want to opt out of electronic documents I can do so by requesting the change through the Statements & Notifications area of my secure account at www.benstrat.com and. A fee may apply for each paper HSA Account Statement sent.

Employee Signature: Date:

First/Last MM/DD/YYYY

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