



Great Lakes HSA

Member FDIC

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). TRUE FALSE
- 2. I am not covered by a health plan, other than a QHDHP, which provides any of the same benefits as the QHDHP. TRUE FALSE
- 3. I am not eligible for Medicare (age 65) or if I am eligible, I am not enrolled in Part A or B. TRUE FALSE
- 4. I am not a dependent on another person's tax return. TRUE FALSE

If you answered FALSE 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 open an HSA if you are transferring HSA funds from another custodian even if you answered false to any of the four questions above. However you may no longer be qualified to make additional contributions. We recommend you check with your tax advisor before making further contributions.

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, residence 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.

RULES AND CONDITIONS APPLICABLE TO HEALTH SAVINGS ACCOUNTS:

General Information: An HSA is a custodial account which is created exclusively for the benefit of the HSA holder, and which is generally used to pay qualifying medical expenses. If you are eligible, you or your employer can make contributions to your HSA. Qualifying distributions from your HSA are tax-free.

Definitions: High Deductible Health Plan (HDHP) generally means, as defined in IRC Section 223(c)(2), a health plan which satisfies the following requirements regarding deductibles and expenses for tax year 2009:

- (a) For single coverage, the deductible must not be less than \$1,150, with annual out-of-pocket expenses not exceeding \$5,800, or
- (b) For family coverage, the deductible must not be less than \$2,300, with annual out-of-pocket expenses not exceeding \$11,600. The maximum amount of contributions in any one-year that can be made \$3,000 for single coverage, and \$5,950 for family coverage.

Refer to the IRS or to our website, <https://www.americanchartered.com/personalHealthSavings.aspx>, for the current year limits. In general catch up contributions for a spouse must be made into a separate HSA account opened in the name of the spouse.

PERSONAL INFORMATION (REQUIRED): PLEASE PRINT CLEARLY

Name: _____
(First) (Initial) (Last)

Social Security Number: _____ Birth Date: _____

Residence Street Address: _____

City: _____ State: _____ Zip Code: _____

U.S. Patriot Act regulations require that we obtain a valid residential street address from all new customers. If you use a PO Box as an alternate mailing address, you must also provide us with a valid residential street address for verification purposes. Your account will not be opened without this information. In an effort to avoid additional address verification follow up, you may include a copy of your drivers license, a utility bill, or a paystub showing your current residential street address.

Alternate Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Business Phone #: _____

Form of Identification: Driver's License Driver's License Number: _____

Issue Date: _____ Expiration Date: _____ State of Issue: _____

City & State where you were born: _____, _____ Your mother's maiden name: _____
(City) (State)

E-Mail Address (Required for Online Banking and E-Statements): _____ @ _____



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	

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.

RULES AND REGULATIONS

American Chartered Bank is hereby appointed to serve as custodian of my Health Savings Account.

By signing the attached signature card I understand and agree to be bound by the rules and regulations which apply to Health Savings Accounts as established by this Application and the HSA Custodial Agreement and any amendments to them. I also agree to be bound by the Bank's agreements, rules, regulations, 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 they 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.

I 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, social security number and bank routing information.



The Bank must receive a signed signature card before completing the account opening process.

Health Savings Account SIGNATURE CARD		
HSA OWNER'S NAME	DATE	ACCOUNT NUMBER (For Bank Use Only)
HSA ACCOUNT OWNER'S ADDRESS		TYPE OF ACCOUNT <input type="checkbox"/> HSA Checking <input type="checkbox"/> HSA CD
HSA ACCOUNT OWNER'S SIGNATURE		SOCIAL SECURITY #
AUTHORIZED SIGNER'S SIGNATURE (if applicable)		SOCIAL SECURITY #
<p>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.</p> <p>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 the 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.</p> <p>Account number release: I authorize American Chartered Bank to release to my employer account related information necessary to support the posting of electronic credits to my Health Savings account including account number, SSN and bank routing information.</p> <p>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.</p>		

SPOUSAL CONSENT FORM:
Complete this section <u>only</u> if the HSA Account Owner is married and their spouse <u>has not been</u> designated as the primary beneficiary.
*SIGNATURE OF SPOUSE:
SIGNATURE OF WITNESS: (Cannot be HSA account holder or spouse):
<small>* 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.</small>