# Health Savings Account Application

## Eligibility Requirements to open an HSA

**You must answer yes to all the below to be eligible for a health savings account**

- I am covered by a High Deductible Health Plan (HDHP)
- I am not covered by a non-HDHP that provides coverage for any benefit that is also covered under the HDHP (with limited exceptions)
- I am not enrolled in Medicare
- I am not eligible to be claimed as a dependent on another person's tax return

## Individual Information

**The following Personal Information needs to be collected on all customers to Comply with the U.S Patriot Act and will be used for banking and tax reporting purposes only.**

Individual/Employee Name:_____
First Middle Last

Individual Address.: _____
Please list Street address and mailing address if different

_____
City State Zip Code

Social Security Number:_____-_____-_____ Date of Birth _____/_____/_____

Password:_____ Marital Status: Married or Single_____

Telephone number_____ Drivers License #_____ State of _____

Issue Date_____ Expiration_____

Email Address_____

## **Please attach a copy of your DL or other ID to this form**

## Authorized Signor Information:

If you wish to have an authorized signor (Agent) on your HSA please complete the following information:

Authorized Signor Name: _____
First Middle Last

Address: _____
Please list Street address and mailing address if different City State Zip Code

**The following Personal Information needs to be collected on all customers to Comply with the U.S Patriot Act and will be used for banking and tax reporting purposes only.**

Social Security Number: _____-_____-_____ Date of Birth _____/_____/_____

Password:_____ Telephone number:_____
Drivers License/ID #_____ State of _____

Issue Date_____ Expiration Date_____

Email Address_____

****Please attach a copy of Your Drivers License or other ID to this form****

## Beneficiary Option for your Health Savings Account:

In the State of Wisconsin if you wish to designate anyone other than your spouse we will need to have your spouse sign a consent form on your beneficiary form releasing their rights to your account.

Beneficiary: Spouse or Non Spouse
Circle one

Beneficiary: _____ Telephone number_____
First Middle Last

Beneficiary Social Security Number:_____-____-_____ Beneficiary Date of Birth:____/____/____

Address:

_____
Please list Street address and mailing address if different City State Zip Code

Email Address_____

Beneficiary: Spouse or Non Spouse
Circle one

Beneficiary: _____ Telephone number_____
First Middle Last

Beneficiary Social Security Number:_____-____-_____ Beneficiary Date of Birth:____/____/____

Address:

_____
Please list Street address and mailing address if different City State Zip Code

Email Address_____

Individual/Employee Signature verifying all above information and eligibility to contribute:

_____

## Contributions:

Will Contributions be made by employer directly to your account: Y/N **If yes: please sign below**

I acknowledge that _____ (employer) will make contributions to my Health Savings Account at Community Bank:

Contribution Amount: $_____ Frequency:_____

Employee Signature: _____