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_____ Occupation_____

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_____ Occupation:_____

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: ____