



HSA ACCOUNT APPLICATION

405 Silverside Road, Suite 105
Wilmington, DE 19809

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Banking Services Provided by
The Bancorp Bank,
MEMBER FDIC, EQUAL HOUSING LENDER

Powered by The Bancorp Bank

PART 1: Personal Information - Primary Account Holder

Please Fill Out Both Sides Completely

First Name:	MI:	Last Name:	Date of Birth: / /
SSN/Tax ID:		Driver's License # and State Issued:	
Address:			Apt./Box#:
City:	State:	Zip:	
Work Phone:	Home Phone:	Email:	

PART 2: Checks

Yes, I would like an order of checks.*

*Name and address of Primary Account Holder will appear on checks.

Add primary applicant home phone to checks.

PART 3: Debit Card

Yes, please send me a Debit MasterCard® Card.

PART 4: HSA Information

Contribution	
Contribution Amount \$ <input type="text"/>	Contribution for Tax Year <input type="text"/> (ex. 2003)
Contribution Source (Check one) <input type="checkbox"/> Employee <input type="checkbox"/> Employer <input type="checkbox"/> Self Employed <input type="checkbox"/> Medicare + Choice	
Type of HSA Contribution <input type="checkbox"/> Regular HSA <input type="checkbox"/> Transfer HSA <input type="checkbox"/> Rollover HSA	
Requirements	
<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Are you covered by or do you have an application pending for a High Deductible Health Plan (HDHP)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Is the HDHP provided by your employer or spouse's employer, or if self-employed, have you provided the plan for yourself?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Do you certify that you are not covered by a health plan, other than a HDHP, which offers the same benefits as an HDHP?
If you answered any of the above questions NO, you are not eligible to establish an HSA. Upon completion of questions 1 through 3 you may complete the "Signature" Section.	

PART 5: Power of Attorney (POA) (Optional)

Since regulations require that only one individual owns the HSA Account, the account holder may want their spouse and/or another third party through Power of Attorney to write checks or use their Debit Card. I (account holder) hereby designate the following individual as additional authorized signer on my Health Savings Account.

Spouse/Other First Name:	MI:	Last Name:	Date of Birth: / /
Social Security Number:			Date of Birth: / /

Please mail your opening deposit check made payable to My Health Savings Bank in a postage-paid envelope, or send it to My Health Savings Bank, 405 Silverside Road, Suite 105, Wilmington, DE 19809

PART 6: Designation of Beneficiaries *(Important: Please read before signing)*

The following individual(s) or entity shall be my primary and/or contingent beneficiary(ies). 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 HSA. Multiple contingent beneficiaries with no share percentage indicated will also be deemed to share equally. If any 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(ies) shall be increased on a pro rata basis. If no primary beneficiary(ies) survives me, the contingent beneficiary(ies) shall acquire the designated share of my HSA.

PLEASE PROVIDE: Name and Address, Relationship, Date of Birth, Social Security Number, Primary or Contingent, and Share (%)

1.
2.

Spousal Consent:

This section should be reviewed if either the trust of the residence of the HSA holder is located in a community or martial property state and the HSA holder is married. Due to important tax consequences of giving up one's community property interest, individuals signing this section should consult with a competent or legal tax advisor.

CURRENT MARITAL STATUS

I am not married - I understand that if I become married in the future, I must complete a new HSA Designation of Beneficiary form.

I am married - I understand that if I chose to designate a primary beneficiary other than my spouse, my spouse must sign below.

I am the spouse of the above named HSA 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 HSA, I have been advised to see a tax professional. I hereby give the HSA holder any interest I have in the funds or property deposited in this HSA and consent to the beneficiary designation(s) indicated above. I assume full responsibility for any adverse consequences that may result. No tax or legal advice was given to me by the Custodian.

Spouse - Signature Required	Date:	Notary - Signature Required	Date:
	/ /		/ /

PART 7: Required Signatures *(Important: Please read before signing)*

I understand the eligibility requirements for the type of Health Savings Account (HSA) deposit I am making and I state that I do qualify to make the deposit. I have reviewed a copy of the Application, the HSA Agreement and the Disclosure Statement available at www.MyHealthSavingsBank.com.

I understand that the terms and conditions which apply to this HSA are contained in this Application and the agreement. I agree to be bound by those terms and conditions. Within seven (7) days from the date I open this HSA I may revoke it without penalty by mailing or delivering a written notice to the Custodian.

I assume complete responsibility for:

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

This deposit account is subject to all applicable rules and regulations adopted by The Bancorp Bank. My signature acknowledges my acceptance of the Truth in Savings Disclosure governing these accounts. The Bancorp Bank may order a consumer report from a credit reporting agency in order to evaluate whether to issue a Debit Card for those consumers who have applied. The Truth in Savings Disclosure is available at www.MyHealthSavingsBank.com.

Primary Applicant - Signature Required	Date:	Power of Attorney - Signature Required	Date:
	/ /		/ /

Under penalties of perjury, I certify that: 1. the number shown on this form is my correct taxpayer identification number (TIN) (or I am waiting for a number to be issued to me), and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding under Internal Revenue Service (IRS) regulations, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the Internal Revenue Service has notified me that I am no longer subject to backup withholding, and 3. I am a U.S. person (including a U.S. resident alien).

CERTIFICATION INSTRUCTIONS - You must cross out item 2 above if you have been notified by the Internal Revenue Service that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return.

THE INTERNAL REVENUE SERVICE DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE CERTIFICATION REQUIRED TO AVOID BACKUP WITHHOLDING.

Primary Applicant - Signature Required	Date:	Power of Attorney - Signature Required	Date:
	/ /		/ /

For Office use only:

Account Number:	Date Opened:	Opened by:
	/ /	
Account Type:	Chex Systems:	