HEALTH SAVINGS ACCOUNT APPLICATION

PART 1. HSA OWNER

Name *(First/MI/Last)* ______________________

Address Line 1 ______________________

Address Line 2 ______________________

City/State/ZIP ______________________

Social Security Number ______________________

Date of Birth ____________ Phone ____________

Email Address ______________________

Account Number ______________________

PART 2. HSA TRUSTEE

To be completed by the HSA trustee

Name ______________________

Address Line 1 ______________________

Address Line 2 ______________________

City/State/ZIP ______________________

Phone ____________ Organization Number ____________

☐ *This is an amendment to an existing HSA.*

☐ *This HSA contains managed investments as described in the Trustee Management of Investment section of the agreement.*

PART 3. CONTRIBUTION INFORMATION

Contribution Amount ______________ Contribution Date ____________

CONTRIBUTION TYPE *(Select one)*

☐ **1. Regular** *(Includes catch-up contributions as well as qualified HSA funding distributions from an IRA)*

Contribution for Tax Year ________ *(Qualified HSA funding distributions from an IRA must be made for the current tax year)*

☐ **2. Rollover** *(Distribution from an HSA or Archer MSA that is being deposited into this HSA)*

By selecting this transaction, I irrevocably designate this contribution as a rollover.

☐ **3. Transfer** *(Direct movement of assets from an HSA or Archer MSA into this HSA)*

PART 4. INVESTMENT AND DEPOSIT INFORMATION

INVESTMENT INFORMATION *(Complete this section as applicable.)*

Investment Description	Quantity or Amount	Investment Number	Term or Maturity Date	Interest Rate

DEPOSIT METHOD

☐ **Cash or Check** *(If the contribution type is transfer, the check must be from a financial organization made payable to the trustee for this HSA.)*

☐ **Internal Account**

Account Number ______________________ Type *(e.g., checking, savings, HSA)* ______________

☐ **External Account** *(e.g., EFT, ACH, wire)*

Name of Organization Sending the Assets ______________________ Routing Number *(optional)* ____________

Account Number ______________________ Type *(e.g., checking, savings, HSA)* ______________

Deposit Taken by ______________________

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PART 5. BENEFICIARY DESIGNATION

I designate that upon my death, the assets in this account be paid to the beneficiaries named below. The interest of any beneficiary that predeceases me terminates completely, and the percentage share of any remaining beneficiaries will be increased on a pro rata basis. If no beneficiaries are named, my estate will be my beneficiary.

☐ I elect not to designate beneficiaries at this time and understand that I may designate beneficiaries at a later date.

PRIMARY BENEFICIARIES *(The total percentage designated must equal 100%.)*

Name ______________________
Address ______________________
City/State/ZIP ______________________
Date of Birth __________ Relationship __________
Tax ID (SSN/TIN) __________ Percent Designated ______

Name ______________________
Address ______________________
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Name ______________________
Address ______________________
City/State/ZIP ______________________
Date of Birth __________ Relationship __________
Tax ID (SSN/TIN) __________ Percent Designated ______

CONTINGENT BENEFICIARIES *(The total percentage designated must equal 100%.) (The balance in the account will be payable to these beneficiaries if all primary beneficiaries have predeceased the HSA owner.)*

Name ______________________
Address ______________________
City/State/ZIP ______________________
Date of Birth __________ Relationship __________
Tax ID (SSN/TIN) __________ Percent Designated ______

Name ______________________
Address ______________________
City/State/ZIP ______________________
Date of Birth __________ Relationship __________
Tax ID (SSN/TIN) __________ Percent Designated ______

Name ______________________
Address ______________________
City/State/ZIP ______________________
Date of Birth __________ Relationship __________
Tax ID (SSN/TIN) __________ Percent Designated ______

Name ______________________
Address ______________________
City/State/ZIP ______________________
Date of Birth __________ Relationship __________
Tax ID (SSN/TIN) __________ Percent Designated ______

☐ *Check here if additional beneficiaries are listed on an attached addendum.* Total number of addendums attached to this HSA __________

PART 6. SPOUSAL CONSENT

Spousal consent should be considered if either the trust or the residence of the HSA owner is located in a community or marital property state.

CURRENT MARITAL STATUS

☐ **I Am Not Married –** I understand that if I become married in the future, I should review the requirements for spousal consent.

☐ **I Am Married –** I understand that if I choose to designate a primary beneficiary other than or in addition to my spouse, my spouse should sign below.

CONSENT OF SPOUSE

I am the spouse of the above-named HSA owner. I acknowledge that I have received a fair and reasonable disclosure of my spouse's property and financial obligations. Because of 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 owner my interest in the assets or property deposited in this HSA and consent to the beneficiary designation indicated above. I assume full responsibility for any adverse consequences that may result.

X ______________________ ______________
Signature of Spouse Date *(mm/dd/yyyy)*

X ______________________ ______________
Signature of Witness Date *(mm/dd/yyyy)*

PART 7. SIGNATURES

Important: *Please read before signing.*
I understand the eligibility requirements for the type of HSA deposit I am making, and I state that I do qualify to make the deposit. I have received a copy of the Health Savings Account Application, the 5305-B Trust Account Agreement, and the Disclosure Statement. I understand that the terms and conditions that apply to this HSA are contained in this Application and the HSA Trust Account Agreement. I agree to be bound by those terms and conditions.

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, and
- the tax consequences of any contributions (including rollover contributions) and distributions.

X ______________________ ______________
Signature of HSA Owner Date *(mm/dd/yyyy)*

X ______________________ ______________
Signature of Witness Date *(mm/dd/yyyy)*

X ______________________ ______________
Signature of Trustee Date *(mm/dd/yyyy)*

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Electric Cooperatives Federal
Credit Union
P.O. Box 194208
1 Cooperative Way
Little Rock, AR 72219-4208

OVERDRAFT SERVICES CONSENT

ATM and One-Time Debit Card Transactions

WHAT YOU NEED TO KNOW ABOUT OVERDRAFTS AND OVERDRAFT FEES

An overdraft occurs when you do not have enough money in your account to cover a transaction, but we pay it anyway. We can cover your overdrafts in two different ways.

1. We have standard overdraft practices that come with your account.
2. We also offer overdraft protection plans, such as a link to a share/savings account or overdraft line-of-credit, which may be less expensive than our standard overdraft practices. To learn more, ask us about these plans.

This notice will explain our standard overdraft practices.

What are the standard overdraft practices that come with my account?

We do authorize and pay overdrafts for the following types of transactions:

- Share Drafts/Checks, and other transactions made using your checking account
- Automatic bill payments
- ACH transactions

We do not authorize and pay overdrafts for the following types of transactions unless you ask us to (see below):

- ATM transactions
- One-time debit card transactions

We pay overdrafts at our discretion, which means we do not guarantee that we will always authorize and pay any type of transaction.

If we do not authorize and pay an overdraft, your transaction will be declined.

What fees will I be charged if the Credit Union pays my overdraft?

Under our standard overdraft practices:

- We will charge you a fee of $20.00 each time we pay an ATM or debit card transaction overdraft.
- There is no limit on the total fees we can charge you for overdrawing your account.

What if I want the Credit Union to authorize and pay overdrafts on my ATM and one-time debit card transactions?

If you want us to authorize and pay overdrafts on ATM and one-time debit card transactions, complete the Section below and mail it to: Electric Cooperatives FCU; P.O. Box 194208; Little Rock, AR 72219-4208 or you may fax it to: 501-570-2393

If there are multiple owners on the ATM and/or debit card account, either account owner can act on behalf of all owners on this account. Only one (1) account owner signature is needed to add or remove the overdraft coverage.

ADD COVERAGE ☐ I want the Credit Union to authorize and pay overdrafts on my ATM and one-time debit card transactions. I understand I will be charged fees as listed above. ***I have the right to revoke this coverage at any time by contacting the Credit Union in writing.***

REMOVE COVERAGE ☐ I do not want the Credit Union to authorize and pay overdrafts on my ATM and One-time debit card transactions effective July, 1, 2010.

X

Member/Owner Signature Date

Printed Name:______________________________ Member Number:______________________

CREDIT UNION CONSENT CONFIRMATION		
CU Employee Signature	Receive Date	System Add