Citizens State Bank Health Savings Account Signature Card

FOR INTERNAL USE ONLY:

Account Type:	
Account Number:	
Date Opened:	
Verified By Check Systems:	

ELIGIBILITY OF APPLICANT

- ☐ I am eligible to establish a Health Savings Account (HSA).
- ☐ I am or will be covered by a qualified High Deductible Health Plan (HDHP).
- ☐ I am not covered under any other health plan that is not compatible with a Health Savings Account. I am not enrolled in Medicare.
- ☐ I may not be claimed as a dependent on another person's tax return.

APPLICATION

NOTICE: To help the government fight the funding of terrorism and money laundering activities, Federal Law requires that all financial institutions obtain, verify and record information that identifies each person who opens an account. What this means to you: When you open an account we will need you to provide your name, street address, date of birth and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

CREDIT VERIFICATION: Both Applicant and Authorized Signer authorize us to request and obtain one or more credit reports about you from one or more credit reporting agencies for the purposes of considering your application for the HSA, reviewing or collecting any HSA opened for you, or for any other legitimate business purpose.

H S A APPLICANT INFORMATION

Personal Information

First Name and MI:		Social Security Number:	
Last Name:		Date of Birth:	
Street Address:		Primary Phone:	
City/State/Zip:		Secondary Phone:	
Mailing Address:		Email Address:	
City/State/Zip		Debit Card:	

Primary ID **Secondary ID** (If you have listed your Driver's License as a primary ID, you cannot use a State ID as a Secondary ID.)

Driver's License #:		**Secondary ID #:**	
Issuing State:			
Issue Date: (dd/mm/yyyy)		**Issue Date: (dd/mm/yyyy)**	
Expiration Date: (dd/mm/yyyy)		**Expiration Date: (dd/mm/yyyy)**	

TIN/Backup Withholding

Important: Under penalties of perjury, I certify that

☐The number shown above is my correct taxpayer identification number,

☐I am a U.S. citizen or other U.S. person (defined in the instructions),

☐I am exempt from reporting under the Foreign Account Tax Compliance Act (FATCA), and 4) that (check appropriate box):

And that(check appropriate box):

☐I am not subject to backup withholding, because I am exempt from backup withholding, or because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.

☐I am subject to backup withholding.

Signature of Account Holder	**Date**	**Signature of Employer or Agent**	**Date**

Employer Information (if self-employed, Name and Nature of Business) **Plan Information**

Occupation		**Health Plan Coverage:**	☐ Single ☐ Family
Employer Name:		**Effective Date of Coverage:**	
Employer Address:		**Deductible Amount:**	
City/State/Zip:		**Frequency of Deductible:**	

H S A AUTHORIZED SIGNER

First Name and MI:		Social Security Number:	
Last Name:		Date of Birth:	
Street Address:		Primary Phone:	
City/State/Zip:		Secondary Phone:	
Mailing Address:		Email Address:	
City/State/Zip		Debit Card:	☐ Yes ☐ No

Authorized Signer **Date**

ACCOUNT OPTIONS

Initial Contribution:	☐ **Regular** ☐ **Transfer** ☐ **Rollover**
Contribution Year:	

SIGNATURES

As indicated above, I certify that I am eligible to establish this HSA. The terms and conditions that will apply to this HSA are incorporated in this Application and Eligibility Form (Application), the Health Savings Custodial Account Agreement, Deposit Account Agreement and Disclosure and other disclosure and related documents delivered to me at the time of account opening. I am responsible for ensuring that all contributions I make are within the limits established by relevant law, and I am also responsible for the tax consequences of any contributions and distributions related to this HSA. I will consult with my tax or legal advisor if I need advice. I authorize the Authorized Signer identified above to access the HSA account established in connection with this Application.

In addition, by signing below, I (we) am (are) applying for a HSA *Visa Debit Card*. I (we) understand this is not a credit card and that the dollar amount of the purchases made with this card will be deducted from my (our) checking account only. I (we) authorized the bank to verify the information provided above and to request a credit report if necessary. The HSA *Visa Debit Card* is available for qualified customers only. Other requirements apply. I (we) agree to be bound by the terms and conditions covered in the appropriate Disclosure Statement and Card Holder Agreement.

The Authorized Individual(s) signing below agree(s), jointly and severally if multiple signers, to the terms set forth in the Deposit Account Agreement and Disclosure, the Time Certificate of Deposit or Confirmation of Time Deposit Agreement (if applicable), the Rate and Fee Schedule, the Funds Availability Policy Disclosure, the Substitute Check Policy Disclosure, the Electronic Funds Transfer Agreement and Disclosure, (if applicable), and acknowledge receipt of our privacy policy (if applicable), as amended by the Financial Institution from time to time. Each of the Authorized Individual(s) signing also acknowledges that the Financial Institution provided at least one copy of these deposit account documents.

Account Holder Print Name		Authorized Signer Print Name	
Account Holder Signature		Authorized Signer Print Name	
Date:		Date:	

Health Savings Custodial Account Agreement

Account:	Custodian: Citizens State Bank of New Castle
Owner:	1238 Broad Street / PO Box C
	New Castle, IN 47362

The account owner named above is establishing this health savings account (HSA) under section 223(a) of the Internal Revenue Code (IRC) exclusively for the purpose of paying or reimbursing qualified medical expenses of the account owner, his or her spouse, and dependents. The account owner represents that, unless this account is used solely to make rollover contributions, he or she is eligible to contribute to this HSA; specifically, that he or she: (1) is covered under a high deductible health plan (HDHP); (2) is not also covered by any other health plan that is not an HDHP (with certain exceptions for plans providing preventive care and limited types of permitted insurance and permitted coverage); (3) is not enrolled in Medicare; and (4) cannot be claimed as a dependent on another person's tax return.

The account owner and the custodian make the following agreement:

Article I

The custodian will accept additional cash contributions for the tax year made by the account owner or on behalf of the account owner (by an employer, family member or any other person). No contributions will be accepted by the custodian for any account owner that exceeds the maximum amount for family coverage plus the catch-up contribution.

Contributions for any tax year may be made at any time before the deadline for filing the account owner's federal income tax return for that year (without extensions).

Rollover contributions from an HSA or an Archer Medical Savings Account (Archer MSA) (unless prohibited under this agreement) need not be in cash and are not subject to the maximum annual contribution limit set forth in Article II.

Qualified HSA distributions from a health flexible spending arrangement or health reimbursement arrangement must be completed in a trustee-to-trustee transfer and are not subject to the maximum annual contribution limit set forth in Article 11.

Qualified HSA funding distributions from an individual retirement account must be completed in a trustee-to-trustee transfer and are subject to the maximum annual contribution limit set forth in Article II.

Article II

For calendar year 2016, the maximum annual contribution limit for an account owner with single coverage is $3,350.

For calendar year 2016, the maximum annual contribution limit for an account owner with family coverage is $6,750. This amount increase Contributions to Archer MSAs or other HSAs count toward the maximum annual contribution limit to this HSA.
For calendar year 2015, an additional $1,000 may be made for an account owner who is at least 55 or older and not enrolled in Medicare.

Contributions in excess of the maximum annual contribution limit are subject to an excise tax. However, catch-up contributions are not subject to an excise tax.

Article III

It is the responsibility of the account owner to determine whether contributions to this HSA have exceeded the maximum annual contribution limit described in Article II. If contributions to this HSA exceed the maximum annual contribution limit, the account owner shall notify the custodian that there exist excess contributions to the HSA. It is the responsibility of the account owner to request the withdrawal of the excess contribution and any net income attributable to such excess contribution.

Article IV

The account owner's interest in the balance in this custodial account is nonforfeitable.

Article V

No part of the custodial funds in this account may be invested in life insurance contracts or in collectibles as defined in IRC section 408(m).
The assets of this account may not be commingled with other property except in a common trust fund or common investment fund.
Neither the account owner nor the custodian will engage in any prohibited transaction with respect to this account (such as borrowing or pledging the account or engaging in any other prohibited transaction as defined in IRC section 4975).

Article VI

Distributions of funds from this HSA may be made upon the direction of the account owner.

Distributions from this HSA that are used exclusively to pay or reimburse qualified medical expenses of the account owner, his or her spouse, or dependents are tax-free. However, distributions that are not used for qualified medical expenses are included in the account owner's gross income and are subject to an additional 20 percent tax on that amount. The additional 20 percent tax does not apply if the distribution is

Health Savings Custodial Account Agreement

Made after the account owner's death, disability, or reaching age 65.

The custodian is not required to determine whether the distribution is for the payment or reimbursement of qualified medical expenses. Only the account owner is responsible for substantiating that the distribution is for qualified medical expenses and must maintain records sufficient to show, if required, that the distribution is tax-free.

Article VII

If the account owner dies before the entire interest in the account is distributed, the entire account will be disposed of as follows:

1. If the beneficiary is the account owner's spouse, the HSA will become the spouse's HSA as of the date of death.
2. If the beneficiary is not the account owner's spouse, the HSA will cease to be an HSA as of the date of death. If the beneficiary is the account owner's estate, the fair market value of the account as of the date of death is taxable on the account owner's final return. For other beneficiaries, the fair market value of the account is taxable to that person in the tax year that includes such date.

Article VIII

The account owner agrees to provide the custodian with information necessary for the custodian to prepare any report or return required by the IRS.

The custodian agrees to prepare and submit any report or return as prescribed by the IRS.

Article IX

Notwithstanding any other article that may be added or incorporated in this agreement, the provisions of Articles I through VIII and this sentence are controlling. Any additional article in this agreement that is inconsistent with section 223 or IRS published guidance will be void.

Article X

This agreement will be amended from time to time to comply with the provisions of the Code or IRS published guidance. Other amendments may be made with the consent of the persons whose signatures appear below.

ACCOUNT OWNER:

Authorized Signer	**Date**

CUSTODIAN:

Authorized Signer	**Date**

HEALTH SAVINGS ACCOUNT DESIGNATION OF BENEFICIARY

Account:	Custodian: Citizens State Bank of New Castle
Owner:	1238 Broad Street / PO Box C
Account No.	New Castle, IN 47362

DESIGNATION OF BENEFICIARY(IES). I designate the following individual(s) or entity(ies) as my primary and/or contingent beneficiary(ies) of this Health Savings Account (HSA).

If I have not indicated whether an individual or entity is a primary or contingent beneficiary, the individual or entity will be deemed to be a primary beneficiary. If I have designated more than one primary beneficiary but no share percentage, the beneficiaries will be deemed to own equal share percentages in the HSA. This will also be true for contingent beneficiaries if no share percentage is otherwise indicated below. If any beneficiary, primary or contingent, dies before I do, his or her interest and that of his or her heirs shall terminate, and the share percentage of any remaining beneficiaries will increase on a pro rata basis. If no primary beneficiary(ies) survives me, any contingent beneficiaries will acquire the designated share of my HSA.

Beneficiary's Name and Address	DOB	SSN/TIN	Relationship	Contingent	Share %

SPOUSAL CONSENT. Note: Consult your tax or legal advisor regarding the consequences of naming beneficiaries in community property states and/or of providing spousal consent to such designation.

☐ **I am married.** I understand that if I designate a primary beneficiary other than my spouse, my spouse must consent by signing below.

☐ **I am not married**. I understand that if I marry in the future, I must complete a new Health Savings Account Designation of Beneficiary form.

Signature of Spouse	Date

Signatures:

Account Owner Signature	Date

Custodian Signature	Date