



American Health Value

Your Health Savings Account Experts

Health Savings Account Application

800-914-3248

This is not your Medical Insurance Policy; contact your insurance carrier (or agent) to make changes to your insurance.

IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING A NEW ACCOUNT:

To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: When you open an account, we will ask for your name, 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.

ACCOUNT HOLDER INFORMATION (Please print clearly)

Drivers License # _____ State of Issue _____
Name _____ Social Security # _____ Date of Birth _____
Email Address (Required) _____ Mother's Maiden Name _____
Mailing Address _____
City _____ State _____ Zip _____
Home Phone (_____) _____ Work Phone (_____) _____
Residential Address (not a PO Box) _____
City _____ State _____ Zip _____

AUTHORIZED SIGNER (OPTIONAL)

Since IRS regulations require that only one individual owns the HSA Account, the account holder may want their spouse and/or authorized signer 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.

Name _____ Social Security # _____ Date of Birth _____

INSURANCE INFORMATION

Insurance Carrier _____ Effective Date of Policy _____ Deductible \$ _____
(Check One) ___ Single Insurance Coverage ___ Dependent Insurance Coverage

EMPLOYER INFORMATION

Div #: _____ Name of Employer _____

PAYMENT ENCLOSED WITH APPLICATION:

Agent ID #: _____	Opening Deposit (minimum \$10.00) \$ _____
Agent Name: _____	Annual Fee (\$36.00) \$ _____
	TOTAL ENCLOSED AMOUNT: \$ _____

Open Date: _____	Grp#/Div: _____	Office use only Acct #: _____	BenCalc: _____	Ck# _____
				Paid Thru _____

BENEFICIARY INFORMATION

In the event of my death, I name as my beneficiary (shares must equal 100%):

Name _____	Name _____
Relationship _____	Relationship _____
Share (% of Holding) _____	Share (% of Holding) _____

BENEFICIARY INFORMATION CONTINUED ON BACK

BENEFICIARY INFORMATION CONTINUED

Spousal Consent: To be completed if your spouse is not listed as your primary beneficiary. This section should be reviewed if either the trust of the residence of the HSA holder is located in a community or marital 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 indicated above. I assume full responsibility for any adverse consequences that may result. The Custodian gave no tax or legal advice to me.

Spouse – Signature Required	Date	Notary – Signature Required	Date

ACCEPTANCE OF TERMS:

By my signature below I understand that **ANNUAL FEES** are **NON-REFUNDABLE** and I apply, and the institution by its signature accepts my application to establish a Health Savings Account pursuant to the terms of the Health Savings Account Agreement and Disclosure Statement (available at www.ahvthebancorp.com), which is incorporated into this application by reference. I authorize the bank to provide American Health Value all data necessary to maintain the account. I/We authorize the transfer of information, as necessary, from my/our account at The Bancorp Bank to my/our account at American Health Value for the purpose of providing bank account summary information.

I understand the American Health Value administrative fee will automatically be deducted from my Health Savings Account on an annual basis. In the event there are not adequate funds in my account to cover the annual fee, you may bill the credit card listed below as an alternate payment source.

	Name on Account	Account Number	Expiration
VISA/MASTERCARD		- - -	

The account holder is responsible for the establishment and maintenance of this account pursuant to Federal guidelines. American Health Value is here to assist the account holder in accomplishing this.

HEALTH SAVINGS ACCOUNT TRUST AGREEMENT:

I acknowledge that I reviewed the Health Savings Account Trust disclosure statement (available at www.ahvthebancorp.com). The trustee or administrator is authorized to act without further inquiry in accordance with writings bearing my signature. I understand that I may revoke the agreement by written notice to the trustee or administrator within seven (7) days after the date of the agreement as specified below.

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.ahvthebancorp.com.

I authorize my Benefit Administrator, American Health Value, and/or The Bancorp Bank (Bank) to make credit and debit entries to my Checking Account/HSA (Account), where the Bank is the custodian thereof, for the sole purpose of correcting any contributions that may be made in error to my Account. For purposes of this Authorization, Bank may also be referred to as the Depository.

Primary Applicant – Signature Required	Date	Authorized Signer– 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 WITHOLDING.

Primary Applicant – Signature Required	Date	Authorized Signer– Signature Required	Date

MAIL COMPLETED APPLICATION TO: American Health Value, P.O. Box 8063, Boise, ID 83707

THE BANCORP BANK

Trustee under the agreement, hereby acknowledges receipt of the above application and successor designation.

_____ (By Authorized Officer)