www.AmericanHealthValue.com
800 914 3248

American Health Value
HSAs Done Right!

Health Savings Account Application

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)

Driver's 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 USER (OPTIONAL)

Since IRS regulations require that only one individual owns the HSA Account, the account holder may want their spouse and/or other authorized user to use their Debit Card. I (account holder) hereby designate the following individual as additional authorized user 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 #: _____

Agent Name: _____

Opening Deposit (minimum $10.00) $_____

Annual Fee ($36.00) $_____

TOTAL ENCLOSED AMOUNT: **$**_____

Office Use Only

Open Date: _____ Acct #: _____ Billing Month: _____

Grp#/Div: _____ BenCalc: _____ Ck# _____ Paid Through Date: _____/_____/_____

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 or 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.

Exclusion of Spouse – Signature Required (if applicable)	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.healthequity.com), which is incorporated into this application by reference.

I authorize the HSA custodian to provide American Health Value all data necessary to maintain the account. I further authorize American Health Value to access the information in my HSA to provide customer support to me. I hereby request the HSA custodian to make my account information available to American Health Value.

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.

Card Type	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:

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 User – Signature Required	Date

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

