



Health Savings Account Application

Opening you account is as EASY as 1-2-3:

1. Complete and sign this form
2. Write a check payable to Wilson Bank & Trust Community Financial Centers for your initial contribution
3. Send these materials to: Wilson Bank & Trust Community Financial Centers, P.O. Box 768 Lebanon, TN 37088

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.

Individual Information

First/M.I./Last: _____ US Citizen: Yes No

Date of Birth: ____ / ____ / ____ Social Security Number ____ - ____ - ____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone Number (Day): _____ (Evening) _____

Drivers License Number: _____ State: _____ Issue Date ____ / ____ / ____ Expiration Date: ____ / ____ / ____

Authorized Signer/Power of Attorney (POA): OPTIONAL

Since the regulations require that only one individual own an HSA account, the account owner may want his/her spouse and/or another third party through power of attorney to write checks or use his/her debit card. I (account holder) hereby designate the following individual as additional authorized signer on my Health Savings Account:

Additional Signer:

First/M.I./Last: _____ US Citizen: Yes No

Date of Birth: ____ / ____ / ____ Social Security Number ____ - ____ - ____

Drivers License Number: _____ State: _____ Issue Date ____ / ____ / ____ Expiration Date: ____ / ____ / ____

Note: Authorized Signer/POA signature required below.

Employer Information

Employer Name: _____

Street Address (No P.O. Box): _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Eligibility Requirements: HSA

Participants in an HSA generally cannot be covered by another health plan (other than the high deductible health plan), except with respect to certain types of "permitted" insurance.

Yes **No**

Account Holder Certification - I certify that: (1) I am covered by a qualified High Deductible Health Plan (HDHP), (2) I am not covered by a health plan, other than an HDHP, which provides any of the same benefits as the HDHP, (3) I am not entitled to benefits under Medicare, and (4) I may not be claimed as a dependent on another person's tax return.

Individual Plan Family Plan

Insurance Carrier: _____ Deductible Amount: _____

Effective Date of coverage by a qualified, high deductible health plan: ____ / ____ / ____

If you answered NO to the above, you are not eligible to establish a qualified HSA. Upon completion of the eligibility requirements, you may complete the signature section on page two.

Contributions

Part I:

Minimum Initial Contribution is \$50.00 (Please make check payable to Wilson Bank & Trust Community Financial Centers)

Initial HSA Contribution: \$ _____ (For tax year: 20 ____)

Is this a rollover? Yes No Amount of rollover contribution: \$ _____

In the case of a rollover from an MSA, I certify that this contribution is a rollover contribution within the meaning of the Internal Revenue Code Section 223, that the rollover is being made within 60 days of receipt by me and I have not received any other rollover in the last 12 months.

Part II:

Future HSA Deposits (For employee contributions only):

Following this initial deposit I would like future contribution to be processed as indicated below:

- Payroll withholding
If yes, please provide the amount you wish to contribute each pay period: \$ _____
- As an individual I would like to transfer funds to my HSA account from y other bank account. *(Please complete the Automatic Funds Transfer Authorization Form.)*
- I would prefer to mail in deposits to my HSA account

Optional Services

Would you like a VISA® Debit Card for use with this account? Yes No

Would you like a second VISA® Debit Card issued for the POA listed on page? This card could be used for normal distributions only. Yes No

Would you like to order additional checks for this account? Yes No

Would you like to view your account balances and activity via the internet? Yes No

If yes, please provide your email address: _____ Mother's maiden name _____

Signatures

I agree to be bound by the account rules and regulations applicable to the Health Savings Account established by Wilson Bank & Trust Community Financial Centers agreements, rules and regulations, and disclosures applicable to this account and any additional accounts that I establish with Wilson Bank & Trust Community Financial Centers in the future as an individual, custodian or single trustee; this master signature card agreement governing additional accounts will remain in effect as long as I continuously maintain at least one covered account with Wilson Bank & Trust Community Financial Centers.

By signing this Application and per the HSA Account options selected above, I am requesting that Wilson Bank & Trust Community Financial Centers issue to my spouse or other authorized third party as indicated above a separate Visa® Debit Card to allow them electronic access to my Health Savings Account and to add their name to my Wilson Bank & Trust Community Financial Centers check order to facilitate access to my Health Savings Account.

In the event you authorize Wilson Bank & Trust Community Financial Centers to transfer funds to your Wilson Bank & Trust Community Financial Centers account, you understand the following:

- If a transfer is made from a savings account, you retain the right to require not less than 7 days written notice of withdrawal.
- If no termination date is specified, this authorization will remain in effect until terminated by the account holder. The account holder may terminate this authorization by giving Wilson Bank & Trust Community Financial Centers 15 days written notice to the following: Wilson Bank & Trust Community Financial Centers, P.O. Box 768, Lebanon, TN 37088.

I certify under penalties of perjury that: (check one)

- I am not subject to backup withholding either because I have not been notified that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the Internal Revenue Service (IRS) has notified me that I am no longer subject to backup withholding.
- I am subject to backup withholding.

The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholdings.

Signature of HSA Account Holder

Date

Signature of Authorized Signer/POA

Date