



HEALTH SAVINGS ACCOUNT WEBSITE APPLICATION

Instructions:

All fields must be completed. For assistance, call 877-448-6500.
Forward applications to: HSA Dept., Founders Bank
6825 W. 111th St., Worth IL 60482

PERSONAL INFORMATION:

Social Security Number: _____ BirthDate: _____ Mother's Maiden Name: _____

HSA Owner's Name: _____

Street Address: _____

(Required)

City _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

FORM OF IDENTIFICATION (Required)

Driver's License State ID Passport ID # _____

E-Mail Address: _____ Issue Date _____ Expiration Date _____

NOTE: 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 to you: When you open an account we will ask for your name, street address, date of birth and other information that will allow us to identify you.

HSA ACCOUNT OPTIONS:

HSA Account Number: _____

Please read Authorized Signer / Power of Attorney section for spousal or third party access to your HSA.
Purchases made with either the debit MasterCard® or Founders Bank checks will be reported by the Bank as "normal distributions" and should only be used for qualified medical expenses. I understand I am responsible for any IRS penalties.

I would like to order one box of checks. Please visit our website www.foundersbank.com or call 877-448-6500 for current check pricing.

I would like a 'no annual fee' debit MasterCard® issued in my name for my account.

I would like to be enrolled in internet banking* **OR** I would like to **add** this account to internet banking (already enrolled)

**I understand that all accounts that I am an owner on will be displayed within Online Banking. I acknowledge that if Online Banking is not used at least once within six months, Online Banking will be cancelled and I would need to reregister for the service.*

I would like to receive my account statements electronically; *enter email address and password (password is case sensitive, must be 7-10 characters and contain both letters and numbers; password will be used to access electronic statement within your existing secure email).*

Email Address: _____ Password _____

I would like to set up an automatic transfer from my Founders Bank account # _____ to my HSA account:

Amount: \$ _____ Frequency: weekly monthly quarterly

INITIAL DEPOSIT:

\$ _____

TYPE OF DEPOSIT:

Regular – Tax Year of Contribution (required) _____ Rollover / Transfer (attach transfer / rollover form)

AUTHORIZATION FOR PAYROLL WITHHOLDING OF HSA CONTRIBUTION (if applicable)

Yes No I hereby authorize my employer to withhold \$ _____ from my paycheck and to deposit that amount into my HSA. I also authorize a copy of the HSA application to be given to my employer. **EMPLOYER NAME** _____

DESIGNATION OF BENEFICIARY(IES)

The following individual(s) or entity shall be my primary and/or contingent beneficiary(ies). If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary beneficiary. If more than one primary beneficiary is designated and no distribution percentages are indicated, the beneficiaries will be deemed to own equal share percentages in the account. Multiple contingent beneficiaries with no share percentage indicated will also be deemed to share equally. If primary or contingent beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining beneficiary(ies) shall be increased on a pro-rated basis. If no primary beneficiary(ies) survives me, the contingent beneficiary(ies) shall acquire the designated share of my account. If no beneficiary is designated or if none of the beneficiaries on file are alive at the time of my death, my HSA assets will be paid to my estate.

PRIMARY Beneficiary Name & Address	Date of Birth	SSN	Relationship	Share
CONTINGENT Beneficiary Name & Address	Date of Birth	SSN	Relationship	Share

Designating an Authorizing Signer

You may wish to designate an authorized signer on your HSA. By designating an authorized signer, you authorize that person to transact business with and give instructions to Founders Bank regarding your HSA. The authorized signer may also make deposits or withdrawals by any means acceptable to Founders Bank, including paper and electronic methods such as ACH and internet-generated transactions. The authorized signer may receive and have access to account information, including account balances and transactions, endorse any instruments such as checks or other documents for the payment of funds and to serve as agent for your Founders Bank Health Savings Account. You authorize Founders Bank to rely upon this authorization and designation until such time Founders Bank receives a written revocation of this authorization and has had reasonable time to act upon the revocation. You understand and agree that you are responsible for ensuring that your authorized signer reads and understands the Founders Bank Deposit Account Information and disclosures provided to you. You hold harmless and indemnify Founders Bank against any claims against or losses Founders Bank may suffer arising out of Founders Bank's reliance on this authorization and release Founders Bank from any liability arising from such reliance, unless otherwise prohibited by law. You understand and agree that you bear sole responsibility for any tax consequences that result from any actions taken by the authorized signer regarding your Health Savings Account. This authorization does not provide ownership or right of survivorship to the authorized signer and terminates upon notification of your death to Founders Bank. Upon your death, rights to funds in your account transfer to your beneficiaries, if named, otherwise to your estate. If you choose to name an Authorized Signer on your Health Savings Account, please complete the section below (please print):

Name: _____ Address: _____
Home Phone: _____ SSN: _____ Date of Birth: _____ Mother's Maiden Name: _____
Driver's License State ID Passport ID #: _____ Issue Date: _____ Expiration Date: _____

I would like a second 'no annual fee' debit MasterCard® issued, for the Authorized Signer / POA listed above.

By signing this Application and per the HSA Account options selected, I am requesting that the Bank issue to my spouse or other authorized third party, as indicated above, a separate debit MasterCard® to allow them access to my Health Savings Account.

Authorized Signer's signature required below.

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 or, effective _____, qualify to make the deposit. Founders Bank is hereby appointed to serve as custodian of my Health Savings Account. I authorize the bank to contact whomever it deems necessary to verify the accuracy of the information above. I have received a copy of the Application, HSA Custodial Agreement, Debit MasterCard® Agreement, HSA Account Disclosure and Fee Schedule as they may be amended from time to time. I also agree to the Bank's agreements, rules and regulations, and disclosures applicable to this account. Within seven (7) calendar days from the date I open this HSA I may revoke the authorization by mailing or delivering a written notice to Founders Bank.

I/We authorize an investigation of my/our credit and release of information about my/our credit experience.

I assume complete responsibility for:

- 1. Determining that I am eligible for an HSA each year I make a contribution.
- 2. Ensuring that all contributions I make are within the limits set forth by the tax laws.
- 3. The tax consequences of any contribution (including rollover contributions) and distributions.

TIN BACKUP WITHHOLDING CERTIFICATION Under penalties of perjury, I certify that

The number shown on page one is my correct taxpayer identification (T.I.N.) (or I am waiting for a number to be issued to me) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest and dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding I am a U.S. person (including a U.S. resident alien). The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Account # _____

Accountholder Signature Date

Signature of Custodian Date

Authorized Signer / POA Signature Date
(Required if Authorized Signer / POA is designated)

FOR OFFICE USE ONLY:

Route **Original Application** to: Switchboard / WO
Route **Copy of Application** to: Card Services / WO HSA Dept / TP IB Dept. Call Center / WO
Route **E-Stmt Enrollment** to: Accounting / WO

Permanent Temporary
Revised: Initials:
