HSA Application and Membership Agreement

P.O. Box 340134
Beavercreek, Ohio 45434-0134
(937) 912-7000 | WPCU.coop

Type of Health Insurance Plan Coverage: ◯ Single ◯ Family WPCU® Account Number: _____

Type of HSA Account ◯ Enhanced

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 to verify your identity. We may also ask to see your driver's license or other identifying documents.

Primary Owner Information *(Single Account Ownership only)*

First Name: _____ MI: _____ Last Name: _____
Address: _____ City: _____ State: _____ Zip: _____
SSN: _____ Date of Birth: _____
Occupancy: ◯ Buying ◯ Own With Mortgage ◯ Government Quarters ◯ Live with Parents ◯ Other
◯ Own - Free & Clear Rent Occupancy Duration: Years _____ Months _____
Email: _____ Home/Mobile Phone: _____
Work Phone: _____ Mother's Maident Name: _____

Membership Application

How Eligible for Membership: _____ Driver's License or Other Gov't ID#: _____
State Issued: _____ ID Issue Date: _____ ID Expiration Date: _____
Citizenship: ◯ US Citizen ◯ Permanent Resident ◯ Non-Resident Alien ◯ Non-Permanent Resident

TIN Certification and Backup Withholding Information

Under penalty of perjury, I certify that the number shown above is my correct Taxpayer Identification Number (TIN), I am exempt from FATCA reporting and:

☐ I am a U.S. person (including a U.S. resident alien), AND

☐ I am not subject to backup withholding, because I am exempt; I have not been notified by the Internal Revenue Service ("IRS") that I am subject to backup withholding as a result of failure to report all interests or dividends; or the IRS has notified me that I am no longer subject to backup withholding, OR

☐ I am subject to backup withholding.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

If you are not a U.S. person or U.S. resident alien, please request and complete a W-8 BEN form.

Employer Information

Employer: _____ Phone Number: _____ Occupation: _____
Employer Address: _____ City: _____ State: _____ Zip: _____
Current Employment Duration: Years _____ Months _____

Authorized Signer *(Optional and applicable only to the HSA account)*

Since regulations require that only one individual owns the HSA, the account holder may want to appoint an agent/authorized signer to have access and transact business on the HSA. I (account holder) hereby designate the following individual as an authorized signer on my HSA. By designating the following individual as my authorized signer on my HSA, I authorize that individual to transact business, such as, but not limited to, make deposits, withdrawals, write checks, use a debit card, if applicable, and receive and have access to account information by any means acceptable to the Credit Union. Authorized signers may not close or amend the HSA. I indemnify and hold the Credit Union harmless from and against any claims, actions, losses, damages, costs, including reasonable attorneys' fees, that the Credit Union may suffer related to and/or arising from the Credit Union's reliance on this authorization and the actions of my authorized agent. I understand that I bear sole responsibility for any tax consequences that result from any actions exercised by my authorized signer regarding my HSA.

First Name: _____ MI: _____ Last Name: _____
Address: _____ City: _____ State: _____ Zip: _____
SSN: _____ Date of Birth: _____
Driver's License or Other Gov't ID#: _____ State Issued: _____ Issue Date: _____ ID Expiration Date: _____

Additional Options

The following options are available on your Health Savings Account. Please check the options you are interested in receiving.

☐ Please issue a Visa® debit card to **me** for my HSA account.

☐ Please issue a Visa® debit card to my **authorized signer** for my HSA account.

Designation of Beneficiaries on HSA *(Important: Please read before signing)*

When the primary TrueSaver® account is opened in conjunction with the HSA the beneficiary(ies) applies to both accounts. The following individual(s) or entity shall be my primary beneficiary(ies). 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 TrueSaver and HSA. If any primary 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 rata basis. If no primary beneficiary(ies) survives me the balance in the account will be payable in accordance with the Health Savings Custodial Account Agreement.

Name: _____ Relationship: _____ Birthdate: _____ Share % _____

Name: _____ Relationship: _____ Birthdate: _____ Share % _____

Spousal Consent *(Required if Residing in a Community or Marital Property State)*

This section should be reviewed if either the trust or 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 seek legal advice and/or consult with a tax professional.

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(s) indicated above, and I agree with and consent to my spouse's designation of a primary beneficiary other than, or in addition to, me. I assume full responsibility for any adverse consequences that may result. No tax or legal advice was given to me by the Custodian.

_____ _____ _____ _____

Spouse – Signature Required | Date | Notary – Signature Required | Date

Signatures

Account Agreement and Authorization

The undersigned hereby authorizes Wright-Patt Credit Union, Inc. (the "Credit Union") to establish this HSA according to my instructions contained in this HSA Application and Membership Agreement. If I am a new member I understand and agree that all sub-accounts opened under this HSA Application and Membership Agreement will have the same ownership interest. This HSA Application and Membership Agreement is a continuing authorization to open any additional sub-accounts on my verbal or written request. I understand that I must execute additional applications to open accounts with different ownership interests. If I am already a primary member and have a previously executed Master Membership Application and Account Agreement on file, all future sub-accounts (except for IRA accounts) will have the same ownership interest as specified in that agreement.

The Credit Union is hereby authorized to recognize the signature(s) subscribed hereto in the payment of funds or the transaction of any business for this account or any sub-account. When considering this HSA Application and Membership Agreement, I authorize the Credit Union to verify my information and obtain credit bureau reports about me. By signing below, I authorize the Credit Union, on an ongoing basis, to obtain credit bureau reports and any other information about me in connection with: (1) extensions of credit; (2) the administration, review or collection of my account; and (3) offering me enhanced or additional products and services. Upon my request, the Credit Union agrees to tell me if a credit report was obtained and give me the name and address of the credit reporting agency that provided the report. The right and authority of the Credit Union under this HSA Application & Membership Agreement shall not be changed or terminated except by written notice to the Credit Union which shall not affect transactions theretofore made.

I acknowledge by providing my email address above, I consent to receive e-mail and electronic marketing materials from the Credit Union. I understand that if I have previously opted out of receiving e-mail and electronic marketing materials from the Credit Union, I will be opted back in by becoming a member, and after becoming a member I can unsubscribe.

By signing below I agree to the terms and conditions of the following documents and to any amendments the Credit Union makes from time to time, all of which are incorporated into this HSA Application & Membership Agreement: (1) the Health Savings Custodial Account Agreement (which includes the Health Savings Custodial Account (IRS Form 5305-C), the Health Savings Custodial Account Disclosure Statement and companying documentation); (2) the Health Savings Account Disclosure; (3) TrueSaver Disclosure; (4) the Important Account Information for Wright-Patt Credit Union® Members brochure containing the Membership and Account Agreement, Electronic Fund Transfers Disclosure and Funds Availability Disclosure; and (5) the General Fee Schedule.

I have read and received copies of this Health Savings Account Application, IRS Form 5305-C and disclosure statement. I agree to be bound to their terms and conditions. I further acknowledge and agree that 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; and (3) the tax consequences of any contributions (including rollover contributions) and distributions. I certify that the information I have provided is true, correct, and complete, and the Custodian may rely on what I have provided. I understand that the Credit Union has no duty or responsibility to determine whether my High Deductible Health Plan ("HDHP") complies with the requirements of Section 223 of the Internal Revenue Code nor to determine or validate whether distributions I take from my HSA are used to pay for qualifying medical expenses. I assume all responsibilities for the HSA transactions I conduct, and I will indemnify and hold the Credit Union harmless from any consequences related to executing my directions. I understand that all investment decisions regarding my HSA are my sole responsibility If I have indicated any amounts as regular contribution for a prior year, I understand the contributions will be credited for the prior tax year. I certify that any deposits I indicate as a "rollover" satisfy the HSA rollover requirements, and that any deposit I represent to be a return of a mistaken distribution was, in fact, a mistake. If the contribution contains rollover dollars, I elect to irrevocably designate this deposit as a rollover contribution. If the contribution contains dollars directly transferred from an IRA as a qualified HSA funding distribution, I irrevocably designate this deposit as a qualified HSA funding distribution. I have been advised to seek competent legal and tax advice and have not been provided any such advice from the Credit Union.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

_____ _____

Signature of HSA Owner Date

Witness: An authorized representative must verify government issued ID (i.e. driver's license, military ID, etc.)

_____ _____

Signature of Representative Name of Business

Or Notary: State of: _____ County of: _____

On this _____ day of _____, 20 _____, before me personally appeared the **HSA Owner** above to me know or proven to be the person described in and who executed the same as his/her free act and deed.

_____ _____

Notary Signature (Commission Expires)