



**Health Savings Account Application/Signature Card**

**Personal Information**

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_ Enrollment Code \_\_\_\_\_  
Address Line 1 (Street Address) \_\_\_\_\_ Address Line 2 (P.O. Box, Apt, etc) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ SSN \_\_\_\_\_ Employer \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_ Mother's Maiden Name \_\_\_\_\_  
Email Address \_\_\_\_\_ Primary Phone \_\_\_\_\_ Alternative Phone \_\_\_\_\_

**USA Patriot Act Requirements**

In accordance with the USA PATRIOT Act, Federal law requires all financial institutions to obtain, verify, and record information that identifies each individual or entity opening an account. This includes all personal and commercial accounts including loan and deposit accounts, as well as trust, brokerage, insurance and investment management accounts. What This Means To Our Customers: When you open an account, you will be asked for your name, address, social security or tax identification number, date of birth (if applicable) and other information that will allow Fifth Third to identify you. You will also be asked to furnish your driver's license or other identifying documents. We are required to follow this procedure each time an account is opened, even if you are a current customer of Fifth Third.

1. Are you a Non-U.S. person with more than \$500,000 on deposit or invested with Fifth Third Bank? Yes  No   
2. Are you a Senior Foreign Official of a government branch, military branch, political party, foreign government-owned company, or a close personal or professional associate of one of these persons? Yes  No

**Insurance Information**

To open an HSA, you are required to meet the following three criteria:

- 1. You are covered by a qualified high deductible health plan.
- 2. You are not covered by another health plan, including Medicare.
- 3. You are not claimed as a dependent on another person's insurance policy.

Insurance Company Name \_\_\_\_\_ High Deductible Plan Start Date \_\_\_\_\_  
Subscriber Number (optional) \_\_\_\_\_ Coverage Type (Check one)  Individual  Family Deductible Amount \_\_\_\_\_  
Insurance Company Customer Service Number \_\_\_\_\_ Employment Start Date (optional) \_\_\_\_\_

**Dependent Information (optional)**

If you have family coverage, please complete the following information regarding dependents that are covered by your health plan. The information can be used to track qualified medical expenses associated with the dependent using our online expense-tracking tool.

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last Four of SSN \_\_\_\_\_ Zip Code of Primary Residence \_\_\_\_\_ Relationship \_\_\_\_\_  
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First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last Four of SSN \_\_\_\_\_ Zip Code of Primary Residence \_\_\_\_\_ Relationship \_\_\_\_\_  
-----  
First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last Four of SSN \_\_\_\_\_ Zip Code of Primary Residence \_\_\_\_\_ Relationship \_\_\_\_\_  
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First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last Four of SSN \_\_\_\_\_ Zip Code of Primary Residence \_\_\_\_\_ Relationship \_\_\_\_\_

## Designation of Beneficiary(ies)

The following individual(s) or entity shall be my primary and/or contingent death beneficiary(ies). If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary death beneficiary. If more than one primary death beneficiary is designated, the death beneficiaries will be deemed to own equal share percentages in the HSA. Multiple contingent death beneficiaries will also be deemed to share equally.

If any primary or contingent death beneficiary dies before I do, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining death beneficiary(ies) shall be increased on a pro rata basis. If no primary death beneficiary(ies) survives me, the contingent death beneficiary(ies) shall acquire the designated share of my HSA.

Primary       Contingent

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Phone \_\_\_\_\_ Relationship \_\_\_\_\_ Share (%) \_\_\_\_\_

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Primary       Contingent

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Phone \_\_\_\_\_ Relationship \_\_\_\_\_ Share (%) \_\_\_\_\_

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## Spousal Consent

This section should be reviewed if either the trust or the residence of the HSA Account Beneficiary is located in a community or marital property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin) and the HSA Account Beneficiary is married. Due to the important tax consequences of giving up one's community property interest, individuals signing this section should consult with a competent tax or legal advisor.

**I am not married** – I understand that if I become married in the future, I must complete a new HSA Designation of Death Beneficiary form.

**I am married** – I understand that if I choose to designate a primary death beneficiary other than my spouse, my spouse must sign below.

**NOTE:** Spouse's signature is **only** required if you want to designate a primary death beneficiary of someone other than your spouse.

I am the spouse of the above-named HSA Account Beneficiary. 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 Account Beneficiary any interest I have in the funds or property deposited in this HSA and consent to the death beneficiary designation(s) indicated above. I assume full responsibility for any adverse consequences that may result. No tax or legal advice was given to me by the Custodian.

\_\_\_\_\_  
Signature of Spouse

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

## Bank Account Settings

Complete the information below to link a bank account to your HSA. The account can be used to make electronic contributions to your HSA or to receive electronic withdrawals from your HSA.

Account Nickname \_\_\_\_\_ Bank Name \_\_\_\_\_ Routing Number \_\_\_\_\_

Account Number \_\_\_\_\_ Account Type \_\_\_\_\_ Customer Service No. \_\_\_\_\_

### Authorized Signer

Since regulations require that only **one individual** can own an HSA account, the account owner may want his/her spouse or another third party through an **Authorized Signer** to write checks and/or use a debit card. Please complete the section below if you wish to grant Authorized Signer authority to your spouse or another third party. I understand that I assume **sole responsibility** for how this individual ("Authorized Signer") utilizes my HSA Account. By signing below the Authorized Signer acknowledges and agrees that they are able to act on behalf of the HSA account only. Access to other accounts of the HSA owner will not be granted.

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Maiden Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

### Account Services

#### Fifth Third Health Savings Account Debit MasterCard®

Would you like to receive a free Debit MasterCard for your Fifth Third Health Savings Account?

Yes No

Would you like a free Debit MasterCard issued to your Authorized Signer (if applicable)?

#### Check Order

If you would like the option of writing checks from your Fifth Third Health Savings Account, you can place your first order once your HSA is funded. You will receive 50 checks at a cost of \$11.75, which will be charged directly to your Fifth Third Health Savings Account. Orders can be placed via your online HSA or by calling HSA Customer Service @ 1-888-350-5353.

#### Monthly Statements

You can view your monthly HSA statement online by logging into your account at [www.53hsa.com](http://www.53hsa.com). Click on the left menu bar, "My Reports", then "Statements" to view or print out your monthly account statement.

### Signature(s)

**IMPORTANT:** Please read before Signing

I understand the eligibility requirements for the type of HSA deposits that I will be making and I state that I qualify to make deposits in my Fifth Third HSA Checking Account. I have received a copy of the Account Brochure, Disclosure Statement, Fifth Third Bank Rules and Regulations and HSA Custodial Agreement, all of which may be amended from time to time. I understand that the terms and conditions, which apply to the Fifth Third HSA Checking Account, are contained in the items as listed above and I agree to be bound by the terms and conditions of these documents.

#### I ASSUME COMPLETE RESPONSIBILITY FOR:

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

\_\_\_\_\_  
Signature of HSA Account Owner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Authorized Signer (if applicable)

\_\_\_\_\_  
Date