Health Savings Account Application

Instructions

To expedite the enrollment process, please follow these steps:

1. Please print and use blue or black ink only. Do not use pencil.
2. Complete Sections 1 through 5 and sign where indicated.
3. Complete Beneficiary Information and sign where indicated.
4. Return this completed HSA Application, which includes the required Beneficiary Designation, to your employer.

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1. Information about you

❑ Mr. ❑ Mrs. ❑ Ms.

First Name MI Last Name SSN

Date of Birth (mm-dd-yyyy)

Mailing Address

City State Zip

Telephone (day) (evening) Email

2. Information about your health plan

You must be covered by an HSA-compatible health plan.

Name of Carrier Group ID (if applicable)

Subscriber Number Annual Deductible Annual Out-of-Pocket Max

Effective Date of Plan (mm-dd-yyyy)

3. Information about your employer

Name of Company

4. Information about your dependents

If you have additional dependents, make a copy of this page and continue filling in dependent information. If dependents are minors, you may omit the Social Security Number (SSN).

Name of Spouse SSN Date of Birth (mm-dd-yyyy)

Name of Dependent SSN Date of Birth (mm-dd-yyyy)

Name of Dependent SSN Date of Birth (mm-dd-yyyy)

5. Participant contributions

Please indicate below the amount of the maximum employee contribution amount (See page 1 for maximum annual contribution) you wish to make for this year. If you wish to roll over an existing HSA to this account, please contact SHDR at 1-800-930-2441.

Annual Employee Contribution	**Annual Employer Contribution**	**Level of Coverage**
$ _____	**$** _____	☐ **Individual** ☐ **Family**

I understand the eligibility requirements for the type of HSA deposit I am making and will make in the future. Upon signing below, I understand that once the Health Savings Account is opened a letter of confirmation along with a copy of the "HSA Custodial Agreement and Disclosure Statement" will be sent from BB&T. I understand that I may elect to close the HSA account within seven (7) days by notifying my employer and SHDR if I do not agree to the terms and conditions contained therein.

Date **Participant Signature**

Please note: After your application has been processed, you should receive your new Benefit Access VISA® Debit Card within seven to 10 business days. At that time, you will receive a confirmation of your HSA enrollment that will include information on signing up for online banking to access your account.

SHDR
STANLEY, HUNT, DUPREE & RHINE, INC.
Benefit Consultants
A subsidiary of BB&T

Beneficiary Information

Pursuant to the provisions of the Custodial Agreement permitting the designation of a beneficiary or beneficiaries by a participant, I hereby designate the following person or persons as primary and contingent beneficiaries of my HSA payable by reason of my death:

I understand that by not providing any beneficiary information, my beneficiary will default to my estate. I also understand that: 1) if more than one primary beneficiary is designated and no distribution percentages are indicated, the primary beneficiaries listed will share equally; 2) if multiple contingent beneficiaries are listed with no share percentage indicated, the contingent beneficiaries will share equally.

If any primary and/or contingent beneficiary dies before I do, his or her interest and the interest of his or her heirs shall be terminated 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 share based on the share percentage listed.

Effect of Divorce. A divorce decree or a decree of legal separation automatically revokes a designation of your spouse as a beneficiary, unless the decree or a qualified domestic relations order provides otherwise.

Community Property. If the HSA is community property under state law, see the Consent of Spouse for Community Property State Form.

a. Designation of primary beneficiary(ies)

First Name	MI	Last Name	SSN	Share%	Date of Birth	**Relationship** Spouse	Non-Spouse
						❑	❑
						❑	❑
						❑	❑
				Total %			

b. Designation of contingent beneficiary(ies)

First Name	MI	Last Name	SSN	Share%	Date of Birth	**Relationship** Spouse	Non-Spouse
						❑	❑
						❑	❑
						❑	❑

I reserve the right to revoke or change any Beneficiary Designation. I hereby revoke all prior designations (if any) of primary beneficiaries and contingent beneficiaries.

The Custodian will pay all sums payable under the HSA by reason of my death to the primary beneficiary, if he or she survives me, and if no primary beneficiary survives me, then to the contingent beneficiary. I understand that, unless I have provided otherwise above, the Custodian will pay all sums payable to more than one primary beneficiary or to more than one contingent beneficiary, equally to the living beneficiaries in that category.

Date of this Designation

Participant Signature