the Capital Bank

HEALTH SAVINGS ACCOUNT APPLICATION AND ELIGIBILTY FORM

Personal Information

Please fill in all boxes (MM DD YYYY)

Social Security # ☐☐☐ ☐☐ ☐☐☐☐ Birth Date ☐☐ ☐☐ ☐☐☐☐

First Name MI Last Name

Street Address *(Required)*

PO Box City

State Zip **Preferred Mailing Method** ☐ Street Address ☐ PO Box

Home # ☐☐☐ ☐☐☐ ☐☐☐☐ Bus. # ☐☐☐ ☐☐☐ ☐☐☐☐

Form of Identification

☐ Driver's License ☐ State ID

State Abbreviation ☐☐ **ID#**

Issue Date _____ Exp. Date _____

Marital Status _____

E-Mail Address _____

Occupation _____

Employer _____

HSA Account Options

☐ I would like to order 150 non-duplicate checks at a cost of $19.42.

☐ I would like a free debit HSA MasterCard issued in my name for my account.

Type of Initial Deposit – *Check one*

☐ Current Year Contribution
$ _____

Please indicate year ☐☐☐☐

☐ Prior Year Contribution
$ _____

Please indicate year ☐☐☐☐

☐ HSA Transfer
(Please attach HSA transfer request form)

Where did you hear about The Capital Bank?

☐ Google ☐ Website ☐ Friend ☐ Other

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Eligibility Requirements: REGULAR HSA

The individual MUST be eligible by the 1st day of the month to be able to contribute.

☐ Y ☐ N **Account holder certification** – I certify that: (1) I am, or effective _____ will be covered by a
Effective Date of HDHP
(CIRCLE ONE) ***single*** *or* ***family*** qualified High Deductible Health Plan (HDHP), I certify that I am not covered by a health plan, other than a HDHP, which provides any of the same benefits as the HDHP, (2) I am not enrolled in Medicare, and (3) I may not be claimed as a dependent on another person's tax return.

If you answered NO to the above, you are not eligible to establish a qualified HSA.
For purposes of determining eligibility, the first date of eligibility for your High Deductible Health Plan is the initial date of reference. Note, the eligibility requirements for exactly what deductible is considered a High Deductible Health Plan changes annually and you should determine that your Health Plan meets the requirements. Further, The Capital Bank must have received your signed and dated application for a Health Savings Account on or before the date of your eligibility to firmly establish eligibility as of that date. If you submit an application to establish an HSA after your initial date of eligibility under a High Deductible Savings Plan, your The Capital Bank HSA will be considered established as of the date you signed and submitted this application (such application must be accompanied with an initial opening balance of at least $100). To receive tax favored treatment for distributions from the new Health Savings Account which you have established, any qualified medical expenses which you choose to pay from the account must have been incurred after the date that your Health Savings Account is established.

Authorized Signer/Power of Attorney (POA)

Since regulations require only one individual own a Health Savings Account, the Accountholder may want his/her spouse and/or another third party through power of attorney to write checks or use his/her debit card. **The Capital Bank requires a copy of the authorized signer's state issued driver's license or ID prior to opening the account.** I (accountholder) hereby designate the following as an additional authorized signer on my Health Savings Account.

Spouse/Other First **MI** **Last**

Social Security # **Birth Date**

Street Address

PO Box **City**

State **Zip** **Home #**

Form of Identification State Abbreviation

☐ Driver's License ☐ State ID **ID#**

Issue Date_____ Exp. Date_____

Second Debit Card Option

☐ **I would like a second FREE HSA Debit MasterCard issued, for the POA listed above, for my account to be used for normal distributions only.**
I hereby request a second debit card (to be furnished without fees) for the individual shown above to which I have designated my Power of Attorney in reference to this Health Savings Account with The Capital Bank. By designating the individual as my Power of Attorney in this account, I understand and agree that my (POA) may enact all such transactions (such as deposits, withdrawals, and transfers), agreements, and orders as I have the legal right to undertake with the same account. Further, my POA may give instructions to The Capital Bank, access all records, and conduct such business pertaining to the account as is within banking regulations, guidelines, and practices. In this regard, I agree to hold The Capital Bank safe and harmless from all such actions and any consequences from such actions; in such manner indemnifying The Capital Bank against any claims or losses that might be pursued against the institution arising out of The Capital Bank's reliance on the appointment of the individual who I appointed as my POA in this matter. I agree and state that this appointment will remain in full force and effect to such time that I or my legal representative shall deliver or have delivered a notice of revocation of the POA to The Capital Bank and a reasonable amount of time has passed to allow The Capital Bank to take action upon the demands of such notice as is common in prudent business practices.

Signatures *Important: Please read before signing.*

I hereby appoint The Capital Bank as the sole custodian of my Health Savings Account. The Capital Bank is a FDIC insured financial institution. If I so choose, I may revoke the authorization by mailing a written notice to The Capital Bank within seven (7) calendar days from the date I open this Health Savings Account. I assume total and complete responsibility for: 1) determining that I am in fact eligible for a Health Savings Account for any and each year in which I make a contribution to the account; 2) determining that all contributions made into this account by either myself or my POA are within the limits set forth by the tax laws; 3) any tax consequences for all and any specific contribution (including rollover contributions and distributions). The completion and submission of this application to Delta Trust & Bank specifically indicates that I agree to adhere to any and all of the procedures necessary to authorize The Capital Bank to establish my Health Savings Account.

*** Please keep a copy of this application for your personal records and for reference by your designated beneficiary(ies) and/or POA.**

Accountholder Signature **Date** **Authorized Signer/POA Signature** **Date**

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HEALTH SAVINGS ACCOUNT
DESIGNATION OF BENEFICIARIES

Personal Information:

First Name _____ MI ____ Last Name _____

Social Security # ___ - __ - ____ Birth Date __ / __ / ____

Designation of Beneficiaries

My primary and/or contingent beneficiary(ies) shall be the following individual(s), organization or entity. Any individual, organization, or entity indicated will be considered as the primary beneficiary if the account holder does not designate either primary or contingent. If (I), the accountholder designates more than one primary beneficiary, without indicating any specific distribution percentages, the beneficiaries shall be considered as equal beneficiaries. If I am predeceased by either a primary or contingent beneficiary, his or hers interest and those interests of his or her heirs shall likewise be terminated in the entirety. If such a death of either a primary or contingent beneficiary should occur, the remaining beneficiary(ies) shall have their designated share of the account increased on a pro-rated basis. If (I), the accountholder am not survived by any primary beneficiary(ies), the contingent beneficiary(ies) shall acquire the share of my account designated for the deceased primary beneficiary(ies)

Name & Address of Individual *(or of Trust and Trustee)*	**Date of Birth** *(creation date, if Trust)*	**Social Security #** *(TIN, if Trust)*	**Relationship**	**Primary or Contingent**	**Share %**
				☐ Primary ☐ Contingent	
				☐ Primary ☐ Contingent	
				☐ Primary ☐ Contingent	
				☐ Primary ☐ Contingent	
				☐ Primary ☐ Contingent	

Signatures

It is my understanding that I may choose to change, delete, or add such beneficiaries as deemed necessary by myself at such time as I choose and that I may initiate such changes upon the delivery of the proper form to The Capital Bank. The Capital Bank has not, or will never, provide any tax and/or legal advice to me in reference to my choice or choices for beneficiary designation (or changes in such designations).

Please include a state issued driver's license or ID for the account holder and/or any authorized signers when you fax your application.

THIS IS A PRE QUALIFICATION FORM AND DOES NOT GUARANTEE AN ACCOUNT. ONCE SUBMITTED YOU MAY HAVE TO PROVIDE ADDITIONAL PAPERWORK AND/OR IDENTIFICATION UPON REQUEST.

_____

Signature of Account Holder **Date**

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