



Health Savings Account Application



FIRST HSA

1044 MacArthur Rd., Reading, PA 19605
(Ph) 610-678-6000 or 888-769-8696 (fax) 610-678-6818
website: www.1hsa.com

Agent Name: _____
Agent Company: _____
Use Payable to: _____
Only Address: _____
Address: _____
Phone: _____

Checking Account # 56 _____
(First HSA will complete Checking Account Number)

*Name		*Soc. Sec. #		*Date of Birth	
*Mailing Address (if P.O. Box – also provide street address)			*City		*State
*Driver's License # or State ID #			*Issuing State	*Issue Date	*Expiration Date
*Home Phone		Business Phone		Email Address	
Type of initial Deposit: • Current Year Amount \$ • Prior Year Amount \$ • Transfer Amount \$ • Rollover Amount \$					
Contribution Methods: If Direct Deposit: Include voided check- (if no date is selected, the direct deposit will be drawn 5 days after account opening) Complete: \$ _____ *please allow 5 days to set up Amount to withdraw monthly Day of month Initial month					
Company Name			Phone Number		
Address		City		State	Zip Code
Contact Person			Email Address		
Designation of Beneficiary(ies): I hereby certify that if I die before distribution has been completed the value of my Health Savings Account shall be distributed to the Beneficiary(ies) named below. Use a separate paper for additional beneficiaries.					
Primary Name		Soc. Sec #		Relationship	
Percent	Address		City	State	Zip
Contingent Name		Soc. Sec #		Relationship	
Percent	Address		City	State	Zip
Accountholders in the following states must complete this section if married: AR, CA, ID, LA, NY, NM, TX, WI, WA This section should be reviewed if either the trust of the residence of the HSA account owner is located in the community or marital property state and the HSA account owner is married. Due to the important tax consequences of giving up one's community property interest, individuals signing this section should consult with competent tax or legal advisor.					
CURRENT MARITAL STATUS					
<input type="checkbox"/> I Am Not Married – I understand that if I become married in the future, I must complete a new HSA Designation of Beneficiary form. <input type="checkbox"/> I Am Married – I understand that if I choose to designate a primary beneficiary other than my spouse, my spouse must sign below.					
I am the spouse of the above-named HSA account owner. 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 owner any interest I have in the funds or property deposited in this HSA and consent to the beneficiary designations(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		_____ date			
T.I.N. CERTIFICATION (Cross out item (2) if subject to backup withholding). Under penalties of perjury, I certify that: (1) The number shown on this form is My correct taxpayer identification number (or I am waiting for a number to be issued to me), and (2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and (3) I am a U.S. person or resident alien. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.					
*Accountholder Signature				Date	

*Health Insurance Co.: PerfectHealth	*Plan Type: ___ Individual ___ Family	*Annual Deductible:	*Effective Date:
---	--	---------------------	------------------

*Select the HSA Plan Type: **E-Statement** • Will receive statements each month via email
 If e-statement payment is selected, complete e-statement section below.
Paper Statement • Will receive statements each month via US Postal Service

*****FOR E-STATEMENTS (statements by email) complete the following information below*****

The statement information you receive via e-mail will be password protected for your security. The bank assumes no liability for any unauthorized viewing of the statement. **IMPORTANT: Please remember this password.** You will need it each time you access your statement, even after you've saved it in your computer files.) **If no password is provided, the last 4 digits of your social security number will be used.**

Disclosure: As direct owner of the account, I agree and request to receive my monthly deposit statements via e-mail. I understand that if I receive my statement via e-mail, I will not receive a paper-based statement. I understand that if I change my e-mail statement address, I shall notify First HSA or Leesport Bank. If I fail to notify First HSA or Leesport Bank of my e-mail address, I understand there may be a delay in getting my statement. Incorrect e-mail addresses will result in a statement being mailed by US mail and defaulted to the \$5.00 paper statement fee.

Email Address	Password (4-8 characters) *case sensitive & contains no spaces	Signature
----------------------	--	------------------

Please remit with application: Make one check payable to "First HSA" This check should include any current year contributions. During a promotional period, First HSA is waiving our monthly administration fee as long as the Perfect Health Insurance Plan remains in force. This promotion is subject to change without notification. Once the promotional period has ended or the Perfect Health Insurance has been terminated, First HSA administration fees will be charged at the current rate.
Send Application and Remittance to: First HSA, 1044 MacArthur Road, Reading Pa. 19605. Note: **A minimum opening deposit of \$50.00 is required when contributing by check.** No minimum opening balance is required if contributing through direct deposit or payroll deduction.

€Check here if you wish to receive a Visa Debit Card.
 Use of this card acknowledges acceptance of the rules and regulations of Leesport Bank as well as the laws and regulations of any federal or state agency having jurisdiction over the use of the Check Card.

To Order Additional Visa Debit Cards: Include a check made payable to "Leesport Bank" for \$5.00 for each additional card you order, otherwise, your account will be debited for this amount. **The Authorized Signor Section of this application must be completed in order to apply for additional cards.**

Additional Card Holder:

_____	_____
Print Name of Additional Card Holder	Signature of Additional Card Holder

AUTHORIZED SIGNOR SECTION: (Optional): I hereby designate the following individual as **additional authorized signor** on my Health Savings Account to sign checks. Authorized Signor's may also be issued a Debit card at an additional \$5.00 per card. See Check Card Section.

Printed Name	Signature	DOB	SS#
Address	City	State	Zip
			Relationship

Health Savings Account Adoption Agreement:

This agreement when signed by me and accepted by First HSA acting as an agent for Leesport Bank, as Custodian, incorporates the Leesport Bank Health Savings Account Custodial Agreement (the "HSA Agreement"). By signing this Agreement, I acknowledge:

- 1). That there are fees for the First HSA, Health Savings Account.
- 2). That I must be covered by a HSA-qualify "high deductible" health plan to be eligible to make HSA contributions (other than roll-over contributions) or have HSA contributions made by my employer.
- 3). That my HSA has been established for the purpose of paying qualified medical expenses, and if distributions are not used for this purpose, I may be subject to ordinary income and penalty taxes, which I must report to the IRS.
- 4). That no loans may be taken from my HSA and no portion of my HSA may be used as security or collateral for a loan.
- 5). That I am responsible for reporting my HSA and that First HSA has no duty to determine the investment, tax or other consequences resulting from my actions involving my HSA.
- 6). That First HSA is not an insurance company who offers the high deductible insurance plans.
- 7). That I will receive a copy of the HSA Custodial Agreement and Disclosures, Electronic Fund Transfer Agreement and Disclosure, Check and Funds Availability Disclosure, Account Agreement, Truth in Savings Disclosure and Your Financial Privacy at Leesport Financial Corp.
- 8). I understand that First HSA is acting as an agent for Leesport Bank (Member FDIC).

To protect the confidentiality of our customers' account information, please provide a password (1-20 characters), other than your last name. When calling First HSA and Leesport Bank this password will be used as an identifying factor to obtain account information.

PASSWORD: _____

*required fields

Leesport Bank-Member FDIC

*Sign Here X _____
 Signature of Primary Account Holder

 Date