



HSA CIP Form

For basic CIP purposes, we must collect the following information from all parties:

- Copy of valid ID (i.e., unexpired driver's license or an unexpired passport)
- Non-apple email address
- Phone number

HSA Owner:

MOTHER'S MAIDEN NAME: _____

OCCUPATION: _____

Authorized Signer:

MOTHER'S MAIDEN NAME: _____

OCCUPATION: _____

Note: To be eligible to enroll in an HSA:

- You must be enrolled in an HDHP
- Your spouse must not be enrolled in an FSA
- You cannot be enrolled in Medicare or another non-HDHP medical plan
- You cannot be claimed as a dependent on someone else's tax return

- The signature must be original/non electronic on the New Account Form
- Only the fillable sections need to be completed.

HSA APPLICATION	HSA <input type="checkbox"/> TRUSTEE <input type="checkbox"/> CUSTODIAN Apple Bank 122 E 42nd St New York, NY 10168
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Use this *HSA Application* to open a Health Savings Account (HSA).

HSA OWNER INFORMATION	Account/Plan Number: Taxpayer ID Number: Date of Birth: Residence Address: Identification Type: Identification Number: Issued By: Location: Issue Date: Expiration Date: U.S. Citizen: <input type="checkbox"/> Citizen <input type="checkbox"/> Resident Alien <input type="checkbox"/> Non-Resident Alien Country:
Primary Phone: Email Address: Verification: <input type="checkbox"/> Check to indicate that the mailing address is different than the HSA Owner's residential address. <input type="checkbox"/> Check here if amendment	

CONTRIBUTION INFORMATION

Type	Current Year Amount	Carryback Prior Year* Amount	Tax Year	
Regular				Contribution Date: Total Amount: \$
Catch-up (age 55 +)				
Transfer				Contribution Source: <input type="checkbox"/> HSA Owner <input type="checkbox"/> Employer <input type="checkbox"/> Other:
Rollover				
Other:				

* A prior year contribution is made in one tax year and credited for the prior year and must be made by your tax filing due date, excluding extensions.

ELIGIBILITY CERTIFICATION

I am eligible to receive a regular or catch-up contribution, and certify the following:

- True False 1. I am covered under a qualifying High Deductible Health Plan (HDHP) effective .
- True False 2. I am not covered under any other insurance plans that are not HDHP (with certain exceptions for plans providing certain limited types of coverage).
- True False 3. I am not enrolled in Medicare.
- True False 4. I am not able to be claimed as a dependent on someone else's tax return.

INVESTMENT SELECTION

Indicate the investment(s) into which the contribution will be deposited.

Investment Description	Account/Ref. Number	Amount	or	Share Percentage
1.	#	\$		%
2.	#	\$		%
3.	#	\$		%
4.	#	\$		%

ROLLOVER CERTIFICATION

Rollover From: HSA MSA

Rollover Amount: \$ _____ Other: _____

Certification: All questions must be answered, "yes" to be eligible for a rollover.

- | | | |
|--|--------------------------|--------------------------|
| 1. Is the source of the rollover funds from another HSA or Archer Medical Savings Account (MSA)? | Yes | No |
| 2. Is the rollover deposit being completed within 60 days of receipt of the distribution? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is this the only HSA rollover deposit you have made in the last 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |

BENEFICIARY DESIGNATION

Designate beneficiaries below. If the primary or contingent status is not indicated, the individual or entity will be considered a primary beneficiary. After your death, your HSA assets will be distributed in equal shares (unless indicated otherwise) to the primary beneficiaries who survive you. If no primary beneficiaries are living when you die, your HSA assets will be distributed in equal shares (unless otherwise indicated) to the contingent beneficiaries who survive you. The interest of any beneficiary that predeceases the HSA Owner terminates completely, and the share percentage of any remaining beneficiaries will be increased on a pro rata basis. You may revoke or change the beneficiary designation at any time by completing a new *IRA/HSA Beneficiary Designation* form and providing it to the Trustee/Custodian.

Type: <input type="checkbox"/> Primary <input type="checkbox"/> Contingent Share Percentage: _____ % Name: _____ Address: _____ Phone: _____ Tax ID Number: _____ Date of Birth: _____ Relationship to HSA Owner: <input type="checkbox"/> Spouse <input type="checkbox"/> Nonspouse	Type: <input type="checkbox"/> Primary <input type="checkbox"/> Contingent Share Percentage: _____ % Name: _____ Address: _____ Phone: _____ Tax ID Number: _____ Date of Birth: _____ Relationship to HSA Owner: <input type="checkbox"/> Spouse <input type="checkbox"/> Nonspouse
Type: <input type="checkbox"/> Primary <input type="checkbox"/> Contingent Share Percentage: _____ % Name: _____ Address: _____ Phone: _____ Tax ID Number: _____ Date of Birth: _____ Relationship to HSA Owner: <input type="checkbox"/> Spouse <input type="checkbox"/> Nonspouse	Type: <input type="checkbox"/> Primary <input type="checkbox"/> Contingent Share Percentage: _____ % Name: _____ Address: _____ Phone: _____ Tax ID Number: _____ Date of Birth: _____ Relationship to HSA Owner: <input type="checkbox"/> Spouse <input type="checkbox"/> Nonspouse

IRA/HSA Beneficiary Addendum attached and signed for additional beneficiaries.

SPOUSAL CONSENT

HSA owners who reside in or whose HSA is located in a community or marital property state should review this section.

This section may have important tax consequences to you and your spouse. It is your responsibility to determine whether spousal consent is necessary and therefore you should seek the guidance of a tax or legal professional prior to completing.

I Am Not Married – I understand that if I become married in the future, I must complete a new beneficiary designation form that includes the spousal consent provisions.

I Am Married – I understand that if I designate a primary beneficiary other than my spouse, my spouse must sign below.

Consent of Spouse. By signing below, I acknowledge that I am the spouse of the HSA owner and agree with and consent to my spouse's designation of a primary beneficiary other than, or in addition to, me. I understand that with my consent I transfer my community property interest in this HSA to my spouse as his or her separate property. I have been advised to consult a competent advisor and I assume all responsibility regarding this consent. The Trustee/Custodian has not provided me any legal or tax advice.

Signature of

Spouse X _____ Date _____ Witness X _____ Date _____

AUTHORIZED SIGNER

To permit someone else (such as your spouse) to authorize payments from your HSA (e.g., to write checks or use a debit card, if applicable), complete the information below and have the person designated as the Authorized Signer sign the "Acknowledgment" section at bottom. When Nondurable is checked, the authority of the Authorized Signer ends at your incapacity or disability.

Durable Nondurable

Name: _____ **Relationship:** _____
Date of Birth: _____ **Tax ID Number:** _____
Address: _____

HSA AUTHORIZED SIGNER ACKNOWLEDGMENT AND AGREEMENT:

Account Owner Statement: By signing below, you acknowledge and agree that you understand the statements above and have designated the named individual as Authorized Signer on this HSA.

Signature of HSA Owner X _____ Date _____

Authorized Signer Statement: As an Authorized Signer, you understand that you are not the account owner. You agree to immediately notify this financial institution in writing of the account owner's death. You acknowledge and agree that you shall not use this account after the owner's death.

Signature of Authorized Signer X _____ Date _____

ACKNOWLEDGMENT

By signing this *HSA Application*, I certify that the information I have provided is true, correct, and complete, and the Trustee/Custodian may rely on what I have provided. In addition, I have read and received copies of this HSA Application, the applicable IRS Form 5305, and the Disclosure Statement, including the applicable fee schedule, for this HSA. I agree to be bound to their terms and conditions. I understand that the Trustee/Custodian has no duty or responsibility to determine whether my 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 Trustee/Custodian harmless from any consequences related to executing my directions. If I have indicated any amounts as prior year contributions, I understand the contributions will be credited for the prior tax year. I have been advised to seek competent legal and tax advice and have not been provided any such advice from the Trustee/Custodian.

Signature Of HSA Owner X _____ Date _____

Signature Of Authorized Signer X _____ Date _____

Signature of HSA Trustee/ Custodian Representative X _____ Date _____

HSA AUTHORIZED SIGNER DESIGNATION	HSA <input type="checkbox"/> TRUSTEE <input type="checkbox"/> CUSTODIAN Apple Bank 122 E 42nd St New York, NY 10168
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Use the *HSA Authorized Signer Designation* to name or replace the Authorized Signer(s) for a Health Savings Account. This Authorized Signer designation supersedes all prior Authorized Signer designations for this HSA Plan.

HSA OWNER INFORMATION		
Name: Mailing Address:	HSA Plan Number: Taxpayer ID Number: Primary Phone: Email Address:	Date of Birth:
<input type="checkbox"/> Check to indicate that the mailing address is different than the HSA Owner's residential address.		

HSA AUTHORIZED SIGNER DESIGNATION OR REMOVAL
You may revoke or change the Authorized Signer designation at any time by completing a new <i>HSA Authorized Signer Designation</i> form and providing it to the Trustee/Custodian. <input type="checkbox"/> Remove HSA Authorized signer listed below. <input type="checkbox"/> Replace all prior HSA Authorized Signer designations with the HSA Authorized Signer designation below.

HSA AUTHORIZED SIGNER INFORMATION	
NAME AND ADDRESS	Tax ID Number:
	Date of Birth:
	ID Type:
	ID Number:
	ID Issued By:
Capacity:	ID Issuing Location:
	ID Issue Date:
EMPLOYER NAME AND ADDRESS	ID Expiration:
	Unique Identifier:
	Primary Phone:
	Secondary Phone:
	E-Mail Address:
HSA Only (Select One): <input type="checkbox"/> Durable <input type="checkbox"/> Nondurable When Nondurable is checked, the authority of the Authorized Signer ends at the incapacity or disability of the HSA Owner.	

CHECKS AND DEBIT CARD ISSUANCE. I understand that I may receive checks and/or a debit card for my Health Savings Account (HSA), and that these payment tools are intended to be used by me, the HSA owner, and any authorized signer (optional) on the HSA to pay for qualifying medical expenses. I am also responsible for understanding the distribution rules and that such amounts will be reported to the Internal Revenue Service as "normal" distributions at the end of the year. I am aware that I should not use the checks or debit card for any payments that are not qualified medical expenses. I understand any distributions taken or used incorrectly may be subject to taxes and penalties, and I assume full responsibility for my actions.

ADDITIONAL TERMS

HSA AUTHORIZED SIGNER ACKNOWLEDGMENT AND AGREEMENT:
Account Owner Statement: By signing below, you acknowledge and agree that you understand the statements above and have designated the named individual as Authorized Signer on this HSA. Signature of HSA Owner X _____ <div style="text-align: right; margin-right: 100px;">Date</div>
Authorized Signer Statement: As an Authorized Signer, you understand that you are not the account owner. You agree to immediately notify this financial institution in writing of the account owner's death. You acknowledge and agree that you shall not use this account after the owner's death. Signature of Authorized Signer X _____ <div style="text-align: right; margin-right: 100px;">Date</div>

ACKNOWLEDGMENT			
By signing this <i>HSA Authorized Signer Designation</i> , I certify that the information I have provided is true, correct, and complete, and the Trustee/Custodian may rely on what I have provided. I understand that this HSA Authorized Signer Designation supersedes all prior designations for the HSA identified above. In addition, I assume all responsibilities for the elections I have made. I will indemnify and hold the Trustee/Custodian harmless from any consequences related to executing my directions. I have been advised to seek competent legal and tax advice and have not been provided any such advice from the Trustee/Custodian.			
Signature of HSA Owner X _____ <div style="text-align: right; margin-right: 100px;">Date</div>		Signature of Receiving HSA Trustee/Custodian Representative X _____ <div style="text-align: right; margin-right: 100px;">Date</div>	
Signature of HSA Authorized Signer X _____ <div style="text-align: right; margin-right: 100px;">Date</div>			

New Account Information - Consumer

Apple Bank
122 E 42nd St

New York, NY 10168

Date:

Check if applicable: Temporary Replacement

Account Information

Amount Of Deposit \$ 0.00

Plan #

Account Number:

Title of Account:

Account T.I.N.:

Ownership Type:

Product Name:

Words, numbers or phrases preceded by a are applicable only when marked, i.e., . Opened By

Owner #1

NAME AND ADDRESS

Title/Capacity:
Employer Name and Address

Tax ID Number:
Date of Birth:
Primary Phone:
Secondary Phone:
Cell Phone:

ID Type:
ID Number:
ID Issued By:
ID Issuing Location:
ID Issue Date:
ID Expiration:
ID Type:
ID Number:
ID Issued By:
ID Issuing Location:
ID Issue Date:
ID Expiration:
Verification:
Unique Identifier:
E-Mail Address:
OFAC ChexSystems ID Verification

Owner #2

NAME AND ADDRESS

Title/Capacity:
Employer Name and Address

Tax ID Number:
Date of Birth:
Primary Phone:
Secondary Phone:
Cell Phone:

ID Type:
ID Number:
ID Issued By:
ID Issuing Location:
ID Issue Date:
ID Expiration:
ID Type:
ID Number:
ID Issued By:
ID Issuing Location:
ID Issue Date:
ID Expiration:
Verification:
Unique Identifier:
E-Mail Address:
OFAC ChexSystems ID Verification

Owner #3

NAME AND ADDRESS

Title/Capacity:
Employer Name and Address

Tax ID Number:
Date of Birth:
Primary Phone:
Secondary Phone:
Cell Phone:

ID Type:
ID Number:
ID Issued By:
ID Issuing Location:
ID Issue Date:
ID Expiration:
ID Type:
ID Number:
ID Issued By:
ID Issuing Location:
ID Issue Date:
ID Expiration:
Verification:
Unique Identifier:
E-Mail Address:
OFAC ChexSystems ID Verification

OWNER #4

NAME AND ADDRESS

ID Type:

ID Number:

ID Issued By:

ID Issuing Location:

ID Issue Date:

ID Expiration:

ID Type:

ID Number:

ID Issued By:

ID Issuing Location:

ID Issue Date:

ID Expiration:

Verification:

Unique Identifier:

E-Mail Address:

OFAC

ChexSystems

ID Verification

Title/Capacity:

EMPLOYER NAME AND ADDRESS

Tax ID Number:

Date of Birth:

Primary Phone:

Secondary Phone:

Cell Phone:

Verification / Follow-Up

Beneficiary Designation. THE FOLLOWING BENEFICIARY(IES) ARE DESIGNATED:

See Addendum

- 1. 2. 3. 4.

Taxpayer Identification Number Certification

Under penalties of perjury, I certify that:

Exempt payee code, if any:

Exemption from FATCA reporting code, if any:

- 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 (Notice: If you are subject to backup withholding, cross out this line), and
3. I am a U.S. citizen or other U.S. person (defined in the W-9 Instructions), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Taxpayer Identification Number:

Signature

Date

Additional Terms

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 that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

ACKNOWLEDGMENT. By signing this document, the undersigned acknowledge that they have opened the type of account designated above, and have received, understand and agree to be bound by the terms of the Account Agreement for that account type. The undersigned certify that all information provided to the institution is true and accurate. The undersigned acknowledge receipt of the appropriate Account Agreement for the type of account opened and a copy of this institution's Privacy Policy, if one was not previously provided. The undersigned also acknowledge receipt, when applicable, of this institution's Truth In Savings, Funds Availability Policy, Electronic Fund Transfer, Overdraft Services Consent Form, and/or the Substitute Check Policy Disclosure. All signers authorize this institution to make inquiries from any consumer reporting agency, including a check protection service, in connection with this account.

NUMBER OF SIGNATURES REQUIRED:

FACSIMILE ALLOWED

X Date X Date

X Date X Date

For Institution Use