CODE CREDIT UNION
One Good Reason After Another

355 W. Monument Ave., Dayton
415 W. National Rd., Englewood
937-222-8971 - www.CODECU.org

CODE HSA Acct # _____

Date _____

HSA Member Account Agreement / Debit Card Order

HSA TYPE ☐ Family Plan ☐ Individual Plan

Name			SSN (I certify this is my correct SSN)	
Address	City		State	Zip
Mailing Address (if different)				
Home Phone	Cell Phone	E-mail		
Birthdate	Gov't Photo Type & ID Number	State	Issue Date	Expire Date
Employer	Work Phone			

DEBIT CARD ORDER - I would like: ☐ HSA Debit Card

Additional Cards – Family Plan Only *Print name of adult person(s) you are requesting to receive debit cards*

_____ _____ _____

Designation of Beneficiary(ies)

The following individual(s) or entity shall be my primary and/or contingent beneficiary(ies). ***If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary beneficiary.*** *If more than one primary beneficiary is designated and no distribution percentages are indicated, the beneficiaries will be deemed to own equal share percentages in the HSA. Multiple contingent beneficiaries with no share percentage indicated will also be deemed to share equally. If any primary or contingent 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 beneficiary(ies) shall be increased on a pro rata basis. If no primary beneficiary(ies) survives me, the contingent beneficiary(ies) shall acquire the designated share of my HSA.*

No.	Beneficiary's name and address	DOB	SSN	Relationship	Primary or Contingent	Share %
1.					☐ Primary ☐ Contingent	
2.					☐ Primary ☐ Contingent	
3.					☐ Primary ☐ Contingent	
4.					☐ Primary ☐ Contingent	
5.					☐ Primary ☐ Contingent	

IMPORTANT ACCOUNT OPENING INFORMATION: ***Please read before signing***

I understand the eligibility requirements for the type of HSA deposit I am making and I state that I do qualify to make the deposit. I have received a copy of the 5305-C Plan Agreement and the Disclosure Statement. I understand that the terms and conditions which apply to this HSA are contained in this Plan Agreement. I agree to be bound to those terms and conditions. I assume complete responsibility for :

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

Federal law requires us to obtain sufficient information to verify your identity. You may be asked several questions and to provide one or more forms of identification to fulfill this requirement. In some instances we may use outside sources to confirm the information. The information you provide is protected by our privacy policy and federal law.

Everything I have stated in the application is correct to the best of my knowledge. I authorize the credit union to investigate my credit and employment history and obtain reports from consumer reporting agencies. The Ohio law against discrimination requires that all creditors make credit equally available to all creditworthy customers, and that credit reporting agencies maintain separate credit histories on each individual upon request. The Ohio Civil Rights Commission administers compliance with this law. Except as otherwise provided by law or other documents, the undersigned is authorized to make withdrawals from the account(s), provided the required number of signatures indicated above is satisfied. The undersigned personally and as, or on behalf of, the account owner agrees to the by-laws of the credit union, including any requirement to pay a membership or entrance fee, and agree to the terms of, this document and the following Terms and Conditions, Electronic funds Transfers, Substitute checks, Common Features, Privacy, Truth in Savings and Funds Availability.

I understand that all payments and withdrawals made by a HSA debit card or check will be tracked and reported to the IRS as normal distributions on an annual basis. This account should only be used to pay for qualified medical expenses and it is my responsibility to maintain records of all activity as required by the IRS. I understand that if I request a debit card or checks for any individual covered in my family plan that I am authorizing him/her to make purchases and withdrawals on my behalf. In the event that I make this choice the credit union bears no responsibility for any purchase or withdrawal made by them.

I certify under penalties of perjury that I am a U.S. person (including a U.S. resident alien).

Sign X _____ **Date** _____

Custodian (Witness) X _____ **Date** _____