

A. Primary Beneficiary

Percentage	Name of Beneficiary	SS#	Relationship	Beneficiary Date of Birth
____ %	_____	_____	_____	_____
____ %	_____	_____	_____	_____

B. Contingent Beneficiary

Percentage	Name of Beneficiary	SS#	Relationship	Date of Birth
____ %	_____	_____	_____	_____
____ %	_____	_____	_____	_____
____ %	_____	_____	_____	_____
____ %	_____	_____	_____	_____

ELIGIBILITY CERTIFICATION:

I certify that I am covered by a "Qualified High Deductible Health Plan (HDHP) and that I am not covered by a health plan, other than a qualified high deductible health plan, which provides the same benefits as the HDHP.

REQUEST FOR ADDITIONAL SIGNER/DEBIT CARD:

I request that a Visa Debit Card be issued to my spouse or dependent named below. The individual listed below will be an authorized user of my card and account. I will be liable for all charges made by the authorized user. There is an charge of \$3 for each additional card.

Name of Authorized User:

Authorized User's Address:

Authorized User's City: State: Zip Code:

Authorized User's Date of Birth: / / SSN: - -

Signature of Authorized User

Date

SIGNATURES

If this HSA is being established with a regular contribution, I certify that I am covered by a qualified high deductible health plan (HDHP), and that I am not covered by a health plan other than an HDHP that provides any of the same benefits as an HDHP. If this HSA is being established with a rollover or transfer contribution, I certify that the rollover or transfer assets are from another HSA or Archer Medical Savings Account (MSA). I certify that the information provided by me on this Application is accurate, and that I have received a copy of the Application, Health Savings Trust or Custodial Account Disclosure Statement, and amendments thereto. I assume sole responsibility for all consequences relating to my actions concerning this HSA. I understand that I may revoke this HSA on or before seven (7) days after the date of establishment. I have not received any tax or legal advice from the trustee/custodian, and I will seek the advice of my own tax or legal professional to ensure my compliance with related laws. I release and agree to hold the HSA trustee/custodian harmless against any and all claims or losses arising from my actions.

Signature of HSA Owner

Date

Signature of Trustee/Custodian

Date