Farmers State Bank
Member FDIC

Address for Return Mail:
FSB
HSA Processing
Attn: Mary Wise
433 Anchorage Road
Warsaw, IN 46580

Bank Use Only
Checking Acct#_____
Port _____

888-480-2408 * 574-268-4200 * Fax 574-269-7787 * Website: www.fsbanking.com

Health Savings Account Application

Name (first) (middle) (Last)		Soc. Sec. #	Date of Birth (xx-xx-xxxx format)
Physical Address	City	State	Zip
Mailing Address	City	State	Zip
Home Phone ( )	Business Phone ( )	Email	
Enclose photocopies of 2 forms of I.D.			
(for Employer) Contribution Year:_____	Payroll Deduction Amount $_____	Transfer (Attach Transfer Form) Amount $_____	Rollover (Attach Rollover Form) Amount $_____

The Patriot Act: 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 to you: When you open an account we will ask for your name, mailing address, date of birth and other information that will allow us to identify you. We may ask to see your driver's license or other identifying documents.

EMPLOYER INFORMATION

Self-employed contributing with a personal check should choose Employee Contribution
Self-employed contributing with a business check should choose Employer Contribution.

Employee initial Contribution Amount $_____

Employer initial Contribution Amount $_____

Total Initial Contribution Amount $_____

Company Name	Contact Person		
Address	City	State	Zip Code
Phone Number ( )	Fax Number ( )	Email	

DESIGNATION OF BENEFICIARIES

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 account. Multiple contingent beneficiaries with no share percentage indicated will also be deemed to share equally. If primary or contingent beneficiary dies before me, 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-rated basis. If no primary beneficiary(ies) survive me, the contingent beneficiary(ies) shall acquire the designated share of my account. No tax or legal advice was given to me by the custodian or agent, I assume full responsibility for any adverse consequences. If you are married and choose anyone other than your spouse as primary beneficiary, you must complete and return HSA Beneficiary/Spousal consent form.

Name & Address	Date of Birth	Social Security #	Relationship	Primary or Contingent	Share %

ELIGIBILITY REQUIREMENTS: REGULAR HSA

Y N (Circle One) Account holder certification – I certify that: (1) I am covered by a qualified High Deductible Health Plan (HDHP), (2) I certify that I am not covered by a Health plan, other than HDHP, which provides any of the same benefits as the HDHP, (3) I am not entitled to benefits under Medicare, and (4) I may not be claimed as a dependent on another person's tax return.

SHARED ACCOUNT NUMBER

Y N (Circle One) I authorize Farmers State Bank to share my account number with my employer to facilitate HSA contribution.

2012 MW

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HSA APPLICATION and AGREEMENT

HEALTH PLAN INFORMATION

Choose one: I have an **individual** Health Plan Deductible of $_____ I have a **family** Health Plan Deductible of $_____

Health Insurance Company:	Section 125 plan – Pre-Tax ? Yes / No	Plan Effective Date:
Insurance Agent:	Insurance Agency:	Agent Phone Number: ( )

* Maximum yearly contribution for individuals is not to exceed $3100. Maximum yearly contribution for a family is not to exceed $6250.
Note: Maximum HSA contributions are based on insurance coverage for 12 months.

HSA ACCOUNT OPTIONS:

☐ I would like to order 50 non-duplicate checks ($6.50) to be used for normal distributions only.
☐ I would like 1 free debit MasterCard issued in my name for my HSA account to be used for normal distributions only. (see below for additional card)
☐ I would like to order a free additional debit MasterCard, to be issued in authorized signers name, as indicated below.
Note: Purchases made with either my debit card or checks will be reported by the Bank as normal distributions. I understand I should not use my debit card or checks for non-qualifying or non-medical purposes and that I am responsible for any IRS penalties. I understand that I should submit an HSA withdrawal form for any non-qualifying or non-medical transaction.

Optional: I hereby designate the following individual as an additional authorized signer on my Health Savings Account to sign checks, and electronic access to my HSA by a debit MasterCard.

NOTE: If you are using an authorized signer for your HSA, your authorized signer must provide copies of 2 valid forms of ID as well.

Authorized Signer Printed Name	Authorized Signer Signature
Social Security No.	Date of Birth

Yes I would like to make Direct Deposits to my Health Savings Account starting on _____ Direct Deposit Amount $_____ Day of the Month Deposit to be Made. _____

Please include a voided check from the account you wish to withdraw from.

Make check payable to **Farmers State Bank**:

Send Check along with application and forms to:

FSB
HSA Processing
Attn: Mary Wise
433 Anchorage Road
Warsaw, IN 46580

Opening Deposit:	($50.00 Minimum)	$_____
Account Set-Up Fee	($15.00)	$_____
Check order:	($6.50)	$_____
Total Amount of Check to FSB		$_____

HEALTH SAVINGS ACCOUNT ADOPTION AGREEMENT

This Application, when signed by me and accepted by Farmers State Bank, as Custodian, constitutes my adoption of the Farmers State Bank Health Savings Account Custodial Agreement (the "Custodial Agreement") and my acceptance of the terms thereof.
By signing this application, I acknowledge:

1). 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.
2). 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.
3). I am responsible for reporting my HSA and that Farmers State Bank has no duty to determine the investment, tax, or other consequences resulting from my actions involving my HSA.
4). I will receive a copy of the HSA Custodial Agreement and Disclosure Statement in my Introduction Kit.
5). All fees are non-refundable.

BACK-UP WITHHOLDING CERTIFICATE

By signing below you certify under penalties of perjury:
1). The number shown on this form is my correct taxpayer identification number.
2). I am not subject to backup withholding either because I have not been notified that I am subject to backup withholding as a result of failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding. The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

Account Holder Sign Here X_____Date_____