HEALTH SAVINGS ACCOUNT APPLICATION

Employer Information

Employer Name ______________________________

CPS ER# ______________________________

City______________________________ State_____

Fax completed form to SelectAccount at (866) 231-0214

ACCOUNT HOLDER'S INFORMATION

Last Name: ______________________ First Name: ______________________ Middle Initial: ______

Street Address: ______________________________

City: ______________________________ State: _________ Zip Code: _________

Email Address: ______________________ Primary Phone: ______________________

SSN#: ______________________ Date of Birth: ______________________

HEALTH INSURANCE PLAN INFORMATION

Type of HDHP Coverage: ☐ Single ☐ Family

Effective Date of Health Insurance Plan______________________

AUTHORIZATION FOR ELECTRONIC DEPOSIT AND WITHDRAWALS

Bank Information:

☐ Checking or ☐ Savings Account

Bank Name: ______________________ Bank Phone Number: ______________________

Bank ABA Routing Number: __ __ __ __ __ __ __ __ __ Bank Account Number: ______________________

(The ABA routing number is the nine-digit number located in the bottom left corner of your check)

NOTE: HSA Reimbursements will be electronically deposited to this bank account when the HSA debit card is not used.

BENEFICIARY DESIGNATION

Your spouse will be deemed to be your beneficiary. If you have no spouse, your estate will be deemed your beneficiary. You can change your beneficiary designations at any time by signing into your account at www.SelectAccount.com and completing online. The paper Beneficiary Form can be found at www.SelectAccount.com or by contacting customer service at (651) 662-5065 or (800) 859-2144.

HSA & INVESTMENT ACCOUNT MAINTENANCE FEES

HSA Participant Fee - The fee will be deducted from your HSA Account balance monthly unless it is paid by your employer.

Investment Accounts are available for Base Balance funds in excess of $1,000.00. For all basic investment accounts a monthly Investment Account fee of $1.50 will be deducted from your investment account balance.

SIGNATURE

The Account Holder named above is establishing this health savings account (HSA) exclusively for the purpose of paying or reimbursing qualified medical expenses of the account holder, his or her spouse, and dependents. The account holder represents that, unless this account is used solely to make rollover contributions, he or she is eligible to contribute to this HSA; specifically, that he or she: (1) is covered under a qualified high deductible health plan (HDHP); (2) is not also covered by any other health plan that is not a qualified HDHP (with certain exceptions for plans providing preventive care and limited types of permitted insurance and permitted coverage); (3) is not entitled to benefits under Medicare (generally, has not reached age 65); and (4) cannot be claimed as a dependent on another person's tax return.

The Custodial Agreement for this account will be sent to you under separate cover.

______________________________ ______________________

HSA Account Holder Signature | Date

HSA CUSTODIAN INFORMATION

MII Life Inc. d.b.a. SelectAccount • P.O. Box 64193, St. Paul, MN 55164-0193 • www.selectaccount.com • (651) 662-5065 or (800) 859-2144