



# Health Savings Account (HSA) Application



In order to open a Health Savings Account ("HSA") through First Horizon Msaver, Inc., please complete this application. The custodian for your HSA will be First Horizon Bank, a division of First Tennessee Bank National Association. Please contact us at 1-877-662-9276 if you have any questions. Please mail the following to **First Horizon Msaver, P.O. Box 26106, Shawnee Mission, KS 66225.**

- Your completed application
- Initial HSA contribution of at least \$100.00 payable to First Horizon Bank

Once your account is established you will receive: your welcome packet, checks and debit card(s). **Debit card(s) and checks are issued at no charge.**

## PERSONAL INFORMATION

Title  Mr.  Mrs.  Ms.  Dr. Name (First) \_\_\_\_\_ (M) \_\_\_\_\_ (Last) \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address (if different from above) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone Number \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_ Email Address \_\_\_\_\_

## USA PATRIOT ACT INFORMATION (required)

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, street address, date of birth and other information that will allow us to identify you.

Form of Identification  Drivers License  State ID  Passport  Military ID ID# \_\_\_\_\_

State of Issuance \_\_\_\_\_ Date of Issuance \_\_\_\_\_ Expiration Date \_\_\_\_\_ Country(ies) of Citizenship \_\_\_\_\_

## EMPLOYER INFORMATION

Company Name \_\_\_\_\_ Human Resources Contact \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Company Phone Number \_\_\_\_\_ Your Occupation \_\_\_\_\_

## HIGH DEDUCTIBLE HEALTH INSURANCE PLAN INFORMATION

Carrier Name Blue Cross Blue Shield of Vermont Deductible Amount \$ \_\_\_\_\_  Individual  Family

Agent Name \_\_\_\_\_ Agent Phone Number \_\_\_\_\_

Effective date of your coverage by a qualified, high-deductible health plan \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**PARTICIPANTS IN AN HSA CANNOT BE COVERED BY ANOTHER HEALTH PLAN EXCEPT "PERMITTED" INSURANCE PRODUCTS.**

## BENEFICIARY DESIGNATION (see next page for explanation)

### Primary Beneficiary (ies)

Name	Relationship	Social Security #	Date of Birth	Address	% (Must total 100)

### Secondary Beneficiary (ies)

Name	Relationship	Social Security #	Date of Birth	Address	% (Must total 100)

At the time of my death, the primary beneficiary(ies) named above will receive the funds remaining in my HSA. If all of my primary beneficiaries die before me, the secondary beneficiary(ies) named above will receive the funds in my HSA. If a beneficiary dies before me, such beneficiary's share will be reallocated on a pro-rata basis to the other beneficiaries within the same class. If all of the beneficiaries die before me, my HSA funds will be paid to my estate. If no percentages are assigned to beneficiaries, the beneficiaries within such class will share equally. If the percentage total for each beneficiary classification does not equal 100 percent, any remaining percentage will be divided equally among the beneficiaries within such class. If my spouse received the HSA as a result of being named as beneficiary, my spouse may choose to continue the HSA in his or her name by providing a written election to the Custodian and by signing the forms and providing the information the Custodian requires. For any non-spouse beneficiary, the HSA terminates as of my date of death and becomes payable. I understand that in certain states, my spouse's consent may be necessary if I wish to name a person other than, or in addition to, my spouse as a beneficiary and that I should consult with an attorney before making such a beneficiary designation. By making the foregoing beneficiary designation, I represent and warrant to the Custodian that the beneficiary designation satisfies all legal requirements under applicable law and on behalf of myself, my heirs, and my estate, I hereby indemnify and hold the Custodian harmless from and against any and all claims, damages, liabilities and costs (including attorney's fees) arising as a result of the Custodian's payment of my HSA in accordance with the foregoing Beneficiary Designation.

### ADDITIONAL AUTHORIZED SIGNERS (OPTIONAL)

Regulations require that only one individual own an HSA. An account holder may want a spouse, or another third party, to have access to funds within the HSA by naming them as an additional authorized signer. I (account holder) designate the following individual(s) as additional authorized signer(s) on my Health Savings Account. I understand these individuals will receive a Visa® debit card for use on this account.

#### First Additional Signer

Name (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Signature of Authorized Signer \_\_\_\_\_

#### Second Additional Signer

Name (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Signature of Authorized Signer \_\_\_\_\_

### INITIAL HSA CONTRIBUTION Minimum Initial Contribution is \$100.00 (Make check payable to First Horizon).

There is not a fee for your HSA account until you lose or terminate your coverage through BRS. After you are no longer covered by the HDHP through BRS the monthly administration fee of \$2.50 will be automatically debited from your account.

Initial HSA Contribution \$ \_\_\_\_\_ (For Tax Year 20 \_\_\_\_ ) Initial deposit made by Employer \$ \_\_\_\_\_ Individual \$ \_\_\_\_\_

Is this a rollover?  Yes  No In case of a rollover, you certify that this contribution is a rollover contribution within the meaning of Internal Revenue Code Section 223, that the rollover is being made within 60 days of receipt, and you have not received a rollover in the last 12 months.

Amount of rollover contribution \$ \_\_\_\_\_

Please note: Contributions must be prorated based on the effective date of your HSA qualified health plan.

### INVESTMENT INFORMATION

Yes, I'm interested in receiving information about investment options.

#### Yes, I want to open a Health Savings Account!

By signing below, I apply to open a Health Savings Account ("HSA") through First Horizon Msaver, Inc. and certify that the information provided in this Application is correct. I understand that First Horizon Bank, a division of First Tennessee Bank National Association, will be the Custodian for my HSA. I understand that you will send me the HSA Custodial Agreement, Depositors Agreement, Fee Schedule and any disclosures after my account is opened and that I will have seven (7) days from my receipt of those documents to revoke my account without penalty. I agree to be bound by all of the terms and conditions in the Depositors Agreement, the Custodial Agreement, and the Fee Schedule, as they may be amended by First Horizon Bank from time to time, unless I revoke my account within the time frame set forth above. Further, I understand that my Application is subject to acceptance by First Horizon Bank. I understand that the Visa® Debit Card is subject to the terms and conditions that are sent with the Card. I agree to pay all fees applicable to my HSA and authorize First Horizon Bank to deduct such fees from my HSA account. If I have completed the Beneficiary Designation section of this form, I direct that all funds remaining in any HSA at my death be paid to the Beneficiary(ies) as I have designated in that section of this form or in a new Beneficiary Designation that I may file prior to my death with the Custodian. This is a single ownership account in the name of the person identified in this Application, and only that person can designate or change beneficiaries on this account. I acknowledge and agree that First Horizon Bank is solely responsible for providing Custodial account services to me and any administrative services, including: enrollment assistance and documents which may be provided through Marketing Representatives, and access to the toll-free tax assistance help-line to answer any questions concerning HSAs, tax-related matters, qualified medical expenses, or other distributions, will be provided by First Horizon Msaver, Inc. separate and apart from the Custodial services provided by First Horizon Bank. I acknowledge and agree that First Horizon Msaver, Inc. and its affiliates, may provide information to a referring third party concerning the products and services I have obtained. I acknowledge that neither First Horizon Bank nor First Horizon Msaver, Inc. has provided investment advice and that all investment decisions and instructions regarding my HSA will be made solely by me upon consultation with my personal broker or investment advisor. First Horizon Bank is authorized to recognize my signature as set forth below, or the signature of any other person named in the Authorized Signers section of this Application, in the payment of checks or the transaction of any other business on this Account, any one (1) such signature or other authority being necessary.

I have read and consent and agree to the terms of the Customer Agreement described above.

X  
Customer Signature \_\_\_\_\_ Date \_\_\_\_\_

Under penalties of perjury, I certify that (1) the Taxpayer Identification Number (TIN) set forth below is my correct TIN (interest paid, if any, will be reported under this number), and that (2) I am exempt from backup withholding, or I am not subject to backup withholding as a result of a failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding, and (3) that I am a U.S. person (including a U.S. resident alien). Cross out item (2) above if you have been notified that you are subject to backup withholding because of underreporting of interest or dividends on your tax return.

Note: The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

X  
Customer Signature \_\_\_\_\_ Date \_\_\_\_\_ Customer's Taxpayer ID # \_\_\_\_\_