HSA ENROLLMENT FORM

FIFTH THIRD BANK

Instructions

1. Complete entire form in order to open a Fifth Third Bank Health Savings Account.
2. Fax completed form to the **BASIC HSA Department at 269-488-6749.**
3. Mail completed form to **BASIC, Attn: HSA Department, 9246 Portage Industrial Dr., Portage MI 49024.**
4. If you have any questions regarding this form, please contact the **BASIC HSA Department 888-472-4001.**

Account Holder Information

Last Name | First Name | Middle Initial

Social Security Number | Date of Birth

Mother's Maiden Name | Marital Status (Single / Married) | Gender (M / F)

Telephone Number | E-mail Address

Street Address (cannot be a PO Box)

City | State | Zip Code

Employer Information

Employer Name | Division

Hire Date | Employee ID

Insurance Information

To open an HSA, you are required to meet the following criteria:

- *Must be covered under a qualified HDHP*
- *Cannot be:*
  - *Claimed as a dependent on someone else's tax return*
  - *Enrolled in Medicare – but mere eligibility does not disqualify*
  - *Covered under another non-HDHP unless it's "permitted insurance" (dental, vision, AFLAC)*

Insurance Company Name | Plan Start Date | Deductible Amount

HDHP Coverage Level ☐ Self Only ☐ Family/Other

Authorized Signer(s) Information

Regulations require that only one individual can own an HSA account. The account holder may want his/her spouse or a third party through an Authorized User to use a debit card and/or write checks. Please complete the section below if you wish to grant an Authorized User this authority.

Last Name | First Name | Middle Initial

Social Security Number | Date of Birth

Mother's Maiden Name | Marital Status (Single / Married) | Gender (M / F)

Telephone Number | E-mail Address

Street Address (cannot be a PO Box)

City | State | Zip Code

Debit Card Information

Note: You may request a debit card for yourself, for an authorized signer, and/or for Dependent(s). A total of two (2) debit cards are available at no charge for each HSA. There is a charge of $10.00 for each additional card after the first two (2). ***Debit card holders must be at least 18 years of age.***

Would you like to receive a free HSA Debit MasterCard® for your account? ☐ Yes ☐ No

Would you like a free Debit MasterCard® issued to your Authorized Signer listed above (if applicable)? ☐ Yes ☐ No

Direct Deposit Setup Information — *optional*

Complete the information below to link a bank account to your HSA. The account can be used to make electronic contributions to your HSA or to receive electronic withdrawals from your HSA. After linking a bank account, you will be required to verify a deposit to the linked account in the amount of $0.01 – 0.99, and enter the deposit amount upon login to your HSA.

Financial Institution Name

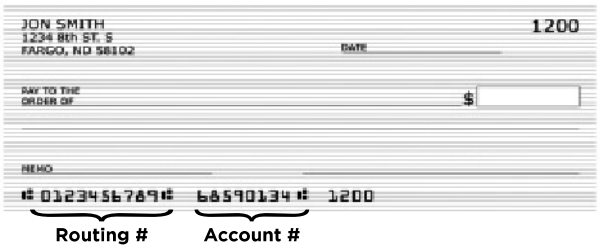
Financial Institution Street Address

City State Zip Code

Account Type: ☐ Checking ☐ Savings

Routing Number

Account Number



Beneficiary Designation Information

The following individual(s) or entity shall be my primary and/or contingent death beneficiary(ies). If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary death beneficiary. If more than one primary death beneficiary is designated, the death beneficiaries will be deemed to own equal share percentages in the HSA. Multiple contingent death beneficiaries will also be deemed to share equally.

If any primary or contingent death 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 death beneficiary(ies) shall be increased on a pro rata basis. If no primary death beneficiary(ies) survives me, the contingent death beneficiary(ies) shall acquire the designated share of my HSA.

If no Beneficiary is named, or if all Beneficiaries pre-decease the owner, the HSA funds will be paid to the estate.

No.	Name and Address	Date of Birth	Social Security Number	Primary or Contingent	Relationship	Share %
1.				☐ Primary ☐ Contingent	☐ Spouse ☐ Dependent ☐ Other	
2.				☐ Primary ☐ Contingent	☐ Spouse ☐ Dependent ☐ Other	
3.				☐ Primary ☐ Contingent	☐ Spouse ☐ Dependent ☐ Other	

Spousal Consent

This section should be reviewed if either the trust or the residence of the HSA Account Beneficiary is located in a community or marital property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin) and the HSA Account Beneficiary is married. Due to the important tax consequences of giving up one's community property interest, individuals signing this section should consult with a competent tax or legal advisor.

☐ I am not married and I understand that if I become married in the future, I must complete a new HSA Designation of Death Beneficiary form.

☐ I am married and I understand that if I choose to designate a primary death beneficiary other than my spouse, my spouse must sign below

I am the spouse of the above-named HSA Account Beneficiary. I acknowledge that I have received a fair and reasonable disclosure of my spouse's property and financial obligations. Due to the important tax consequences of giving up my interest in this HSA, I have been advised to see a tax professional.

I hereby give the HSA Account Beneficiary any interest I have in the funds or property deposited in this HSA and consent to the death beneficiary designation(s) indicated above. I assume full responsibility for any adverse consequences that may result. No tax or legal advice was given to me by the Custodian.

Signature of Spouse Date

Signature of Witness Date

Dependent Information

If you have family coverage, please complete the following information regarding dependents that are covered by your health plan.

Last Name | First Name | Middle Initial

Social Security Number | Date of Birth

Street Address

City | State | Zip Code

Dependent's Relationship to HSA Account Holder | Order Debit Card: ☐ Yes ☐ No

Last Name | First Name | Middle Initial

Social Security Number | Date of Birth

Street Address

City | State | Zip Code

Dependent's Relationship to HSA Account Holder | Order Debit Card: ☐ Yes ☐ No

Last Name | First Name | Middle Initial

Social Security Number | Date of Birth

Street Address

City | State | Zip Code

Dependent's Relationship to HSA Account Holder | Order Debit Card: ☐ Yes ☐ No

IMPORTANT: Please Read Before Signing

I understand the eligibility requirements for the type of HSA deposits that I will be making and I state that I qualify to make deposits in my Fifth Third HSA Checking Account. I understand that the terms and conditions, which apply to the Fifth Third HSA Checking Account, are contained in the Disclosure Statement, Fifth Third Bank Rules and Regulations, and HSA Custodial Agreement. I understand electronic copies of these documents can be located online within my HSA.

I understand that I assume sole responsibility for how this individual ("Authorized User") utilizes my HSA Account. By signing below, the Authorized User acknowledges and agrees that they are able to act on behalf of the HSA account holder only. Access to other accounts of the HSA account holder will not be granted. Signature of Authorized User is required on the last page of this application.

I have read, understand, and agree with the terms and conditions of the Health Saving Custodial Agreement. I acknowledge that I received a copy of the Health Saving Custodial Agreement with my enrollment materials. I may obtain an additional copy of my Health Saving Custodial Agreement by calling 888-350-5353 or visiting www.53hsa.com. I understand and agree by using my health care saving account, I agree to be bound by the terms and conditions of the Health Saving Custodial Agreement.

I ASSUME COMPLETE RESPONSIBILITY FOR:

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

Signature of HSA Account Holder | Date

Signature of Authorized User (if entered on first page) | Date

HSA Enrollment Form

Important Information:

- If you or your spouse have a general purpose Flexible Spending Plan (FSA), you are not eligible to receive or make HSA contributions.
- If you anticipate/plan on enrolling in Medicare and/or Social Security during the calendar year, there is important information you need to know. Please see your HR Department before signing up for HSA.
- For more information you can visit: www.medicare.gov
  - Click on: Sign up/change plan; Signing up for Part A & Part B; Signing up for Medicare special conditions; see the bottom of the page regarding HSA's.
- For tax year 2019, the maximum aggregate annual contribution that an individual can make to an HSA is:
  - **2019** Single Coverage: $3500
  - **2019** Family Coverage: $7000
  - Catch up contributions: $1000 (for individuals age 55 and older)

Participant Information
To be completed by Employee - Please print clearly

Please return completed form to your Employer – All fields are required to open an HSA Account

Employer: _____

Name: _____

SSN: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Medical Coverage: Single Family Effective Date: _____

Annual HSA Contribution: $_____ *Contributions will be made on a per pay basis according to the Employer pay schedule*

HSA Bank Account Information:
Only provide for accounts NOT opened by BASIC or if you already have an account on file with BASIC.
Skip this section if completing a Fifth Third Enrollment form/application

Financial Institution: _____

Routing Number: _____ Account Number: _____

Employee Signature: _____

Contribution Information
This Section to be completed by Employer

Employee Contributions (if applicable): Weekly Bi-Weekly Semi-Monthly Monthly Quarterly Annually

Annual Amount: $_____/# of Pays: _____= Per Pay: $_____ Date of First Deduction: _____

Employer Contributions (if applicable): Weekly Bi-Weekly Semi-Monthly Monthly Quarterly Annually

Annual Amount: $_____/# of Pays: _____= Per Pay: $_____ Date of First Deduction: _____