HEALTH SAVINGS ACCOUNT (HSA)
DEBIT CARD APPLICATION

Name and Address of Financial Institution

DATE: | ACCOUNT/PLAN #: | REPLACEMENT CARD ☐

APPLICANT INFORMATION

Name:
Address:

Capacity:
Employer
Name:
Address:

Tax ID Number:
Date of Birth:
Identifer:
:
:

Card Number:
Issue Date:
Date Ordered:
Expiration Date:

Name:
Address:

Capacity:
Employer
Name:
Address:

Tax ID Number:
Date of Birth:
Identifer:
:
:

Card Number:
Issue Date:
Date Ordered:
Expiration Date:

ACCOUNTS OF ACCESS

Checking- #
Savings- #

LIMITATIONS

:
:
:

NOTE

DEFINITIONS. The terms "you" and "your" refer to the Applicant, whether or not there are one or more Applicants named above, and the terms "us" and "our" refer to the Financial Institution.

DEBIT CARD ISSUANCE. By signing below, you are asserting to us that you understand that you will receive a debit card for your Health Savings Account (HSA) and that this payment tool is intended to be used by you, the HSA owner, and any authorized signer (optional) on the HSA, to pay for qualifying medical expenses. You also understand that such amounts will be reported to the Internal Revenue Service as distributions at the end of the year. You understand any nonqualified distributions may be taxed and, if applicable, subject to an additional IRS penalty tax. You assume full responsibility for your actions.

ACKNOWLEDGMENT. You have applied for the card services noted above. You acknowledge receipt of a copy of the Health Savings Account Agreement, a copy of this institution's Privacy Policy, if one was not previously provided to me, and, when applicable, the Truth In Savings, Electronic Funds Transfer Agreement, and this Application, and you agree to be bound by their terms. You further authorize us to obtain your credit information, such as your credit report, at our option.

X _____ Date

X _____ Date

Authorized by: X _____ Date