Health Savings Account (HSA) Application and Eligibility Form

Instructions: Complete all fields below. Return your application to: **Town of East Hartford, Human Resources, 740 Main Street, East Hartford, CT 06108.** For assistance, call Terry Jones (860) 291-7223, Monday - Friday, 8:30 a.m. – 4:30 p.m.

PART 1: GENERAL INFORMATION FOR PRI ARY ACCOUNTHOLDER

First Name:	MI:	Last Name:	Date of Birth: (mm/dd/yyyy)	Social Security Number:

Street Address: **(Required)**	City:	State:	ZIP Code:

Preferred Mailing Address: ☐ Street Address ☐ P.O. Box	Email:

P.O. Box:	City:	State:	ZIP Code:

Home Phone:	Business Phone:

Citizenship Status: ☐ U.S. Citizen ☐ Resident Alien ☐ Non-resident Alien *(If checked, please provide W8)*	If not a U.S. Citizen, enter Country of Citizenship:

Employment: ☒ Employed ☐ Not Employed ☐ Self-Employed ☐ Retired

Employer: Town of East Hartford	Title/Profession:

Health Plan Insurance: ☐ Single ☐ Family	Effective Date of your Health Insurance:	Deductible Amount: $

PART 2: AUTHORIZED SIGNER *OPTIONAL: (SUCH AS A SPOUSE OR ANOT ER THIRD PA TY)*

By completing all of the fields below, you are authorizing the person designated as "Authorized Signer" to access and initiate transactions on your account as your agent. HSA Bank will rely upon this designation until HSA Bank receives your written revocation of this authorization and has had a reasonable time to act upon it. You hold harmless and indemnify HSA Bank against any claims against or losses arising out of HSA Bank's reliance on this authorization, and release HSA Bank from any liability arising from such reliance, unless otherwise prohibited by law. You remain solely responsible for any tax consequences that result from any actions taken by the authorized signer regarding y ur account.

First Name:	MI:	Last Name:	Date of Birth: (mm/dd/yyyy)	Social Security Number:

☐ Address same as accountholder	Street Address:

City:	State:	ZIP Code:	Phone Number:

If you would like to designate a beneficiary for your account, please complete our Designation of Beneficiaries form which is available on our website at: http://www.hsabank.c m/beneficiary. UPON NOTICE TO HSA BANK F YOUR DEATH, THIS AUTHORIZATION TERMINATES, AND RIGHTS TO FUNDS IN YOUR ACCOUNT WILL BE TRAN FERRED TO YOUR BENEFICIARIES. IF YOU DID NOT NAME A BENEFICIARY, YOUR ACCOUNT BALANCE WILL BE PAYABLE THROUGH YOUR ESTATE.

PART 3: ACCOUNT SELECTIONS

Please select the account options and enter an amount where appropriate.

☐ Primary Accountholder debit card (No Charge)

☐ Authorized Signer debit card *(if applicable)* (No Charge)

☐ Checks ***($7.95 – check must be included to process order.)*** $ _____

☐ Initial Contribution $ _____ Contribution Year _____

Transfer: ☐ Yes ☐ No (*If yes, please attach the HSA transfer/rollover form or IRA form.)*

PART 4: ACCOUNT AUTHORIZ TION

By signing below, I certify that:

- I am, or will be covered by a qualified High Deductible Health Plan (HDHP), I am not enrolled in Medicare or covered under other health insurance that is not compatible with an HSA, and I may not be claimed as a dependent on another person's tax return (excluding spouses per the IRS).
- HSA Bank is hereby appointed to serve as custodian of my Health Savings Account.
- I have received a copy of and agree to the Deposit Account Agreement and Disclosures for Health Savings Accounts, Truth in Savings, and Privacy Statement. HSA Bank, a division of Webster Bank, N.A. and Webster Bank, N.A. are the same FDIC-insured institution. Within seven (7) calendar days from the date I open this HSA, I may revoke authorization for opening the account by mailing a written notice to HSA Bank.
- To help the government fight the funding of terrorism and money laundering activities, Federal Law requires that all financial institutions 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 need you and your authorized signer to provide name, street address, date of birth and other information that will allow us to identify you and your authorized signer. We may also ask to see your driver's license or other identifying documents.

Accountholder Signature:	**Date:**

For Tracking Purposes (to be completed by employer or i surance/financial representative) — Internal Use Only:

Health Plan Code	Broker Dealer	AIN#	SVC	Software	MGA	Marketing	Employer Fed ID #
							066001989