



# Health Savings Account (HSA) application

## Important information about procedures for opening a new account

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 for me: When I open an account, I will be asked to provide my name, address, date of birth, Social Security Number and other information that will allow you to identify me. All information for the Health Savings Account (HSA) owner must be completed and returned before an account can be established.

Employer name City of Sun Prairie
Company code 1000104

Custodian: BMO Harris Bank N.A.  
Attention: HSA Operations

Mailing Address:  
BMO Harris Support Services Corp.  
180 N. Executive Dr.  
Brookfield, WI 53005

## HSA owner information

Name			Email (optional)	Daytime phone number
Street address (no post office box)			Social Security Number (SSN)	
City	State	Zip	Date of birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

## Designation of beneficiary

At the time of my death, the primary beneficiaries named below will receive my HSA assets. If all of my primary beneficiaries die before me, the contingent beneficiaries named below will receive my HSA assets. In the event a beneficiary dies before me, such beneficiary's share will be reallocated on a pro-rata basis to the other beneficiaries that share the deceased beneficiary's classification as a primary or contingent beneficiary. If all of the beneficiaries die before me, my HSA assets will be paid to my estate. If no percentages are assigned to beneficiaries, or if the percentage total for any beneficiary classification exceeds 100 percent, the beneficiaries in that beneficiary classification will share equally. If the percentage total for each beneficiary classification is less than 100 percent, any remaining percentage will be divided equally among the beneficiaries within such class. This designation revokes and supercedes all earlier beneficiary designations that may apply to this HSA.

### A. Primary beneficiary

Percentage	Name of beneficiary	SSN or Taxpayer Identification Number (TIN)	Relationship to HSA owner
%			
%			
%			
<b>Total</b>	<b>100%</b>		

### B. Contingent beneficiary

Percentage	Name of beneficiary	SSN or Taxpayer Identification Number (TIN)	Relationship to HSA owner
%			
%			
%			
<b>Total</b>	<b>100%</b>		

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## Spousal consent

HSA owner initials

\_\_\_\_\_

**I Am Married.** I understand that if I designate a primary beneficiary other than my spouse, my spouse must consent by signing below.

HSA owner initials

\_\_\_\_\_

**I Am Not Married.** I understand that if I marry in the future, I must complete a new Designation of Beneficiary form, which includes the spousal consent documentation.

I am the spouse of the HSA owner. Because of the significant consequences associated with giving up my interest in the HSA, the custodian has not provided me with legal or tax advice, but has advised me to seek tax or legal advice. I acknowledge that I have received a fair and reasonable disclosure of the HSA owner's assets or property, including any financial obligations for a community property state. In the event I have a legal interest in the HSA assets, I hereby give to the HSA owner such interest in the assets held in this HSA and consent to the beneficiary designation set forth in the "Designation of beneficiary" Section.

Signature of spouse

Date

Signature of witness (required)

Date

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Witness cannot be the HSA owner or beneficiary of this HSA)

## Signatures

I certify that (i) I am covered by a qualified high deductible health plan (HDHP), (ii) I am not also covered by any other health plan that is not an HDHP with certain exceptions for plans providing preventative care and limited types of permitted insurance and permitted coverage, (iii) I am not enrolled in Medicare and (iv) I cannot be claimed as a dependent on another person's tax return. I certify that the information provided by me on this Application is accurate, and that I have retained a copy of the Application and the IRS Form 5305-C, *Health Savings Custodial Account*. I agree to be bound by the terms and conditions found in the Application, Health Savings Custodial Account, Health Savings Account Disclosure Statement and amendments thereto. I assume sole responsibility for all consequences relating to my actions concerning this HSA. I have not received any tax or legal advice from the custodian, and I will seek the advice of my own tax or legal professional to ensure my compliance with related laws. I release and agree to hold the HSA custodian harmless against any and all claims or losses arising from my actions related to my HSA.

### I have read, understand and agree to the following:

1. To establish automated contributions, I authorize the custodian to provide my EMPLOYER and/or EMPLOYER-APPOINTED THIRD PARTY BENEFITS PLAN ADMINISTRATOR (TPA) with my new HSA account number. I understand that my HSA account number will not be assigned until the custodian has completed my HSA enrollment. I further authorize my EMPLOYER and TPA to provide my personal information to, or confirm that information with, the custodian.
2. I understand that HSA enrollment is subject to custodian approval and authorize the custodian to notify me, my EMPLOYER and/or TPA if an ACH deposit cannot be completed for any reason.
3. I understand that this product is available with a debit card. Therefore, in applying for this product I am requesting a BMO Harris Bank HSA Debit MasterCard® card be sent to me once my HSA is established. I may elect to purchase personalized HSA checks once my HSA has been established.

Signature of HSA owner

Date

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