

Application & Beneficiary Designation Form *(cont.)*

Pursuant to Section VI of the Custodial Account Agreement, you are authorized to designate one or more individuals as your Account Beneficiary(ies). For each designated person below, include their address, city, state, zip, social security number (if known) and relationship to you in the space provided. You must also designate a percentage of your remaining account (if any) to be distributed to that individual.
 NOTE: All percentages must add up to 100%.

PRIMARY BENEFICIARY(IES)

Name: _____ %: _____
 Address: _____ City: _____ State: _____ Zip: _____
 SSN: _____ DOB: _____ Relationship: _____

Name: _____ %: _____
 Address: _____ City: _____ State: _____ Zip: _____
 SSN: _____ DOB: _____ Relationship: _____

If all individuals listed as Primary Beneficiaries precede you in death or cannot be located after a reasonable search by the custodian, all non allocated funds (if any) in your account will be distributed to your Contingent Beneficiary(ies) designated below. In the event that no beneficiary can be located, your account balance (if any) will be distributed to your estate.

CONTINGENT BENEFICIARY(IES)

Name: _____ %: _____
 Address: _____ City: _____ State: _____ Zip: _____
 SSN: _____ DOB: _____ Relationship: _____

Name: _____ %: _____
 Address: _____ City: _____ State: _____ Zip: _____
 SSN: _____ DOB: _____ Relationship: _____

Name: _____ %: _____
 Address: _____ City: _____ State: _____ Zip: _____
 SSN: _____ DOB: _____ Relationship: _____

Note: Special rules apply in certain states if a married individual does not select his/her spouse as beneficiary. If you reside in a community or marital property state and designate a person other than your spouse as beneficiary, you must obtain authorization from your spouse. It is the responsibility of the Account Holder to ensure that the individual(s) designated as beneficiary(ies) are legally authorized to act in that fashion.

ELECTRONIC FUNDS TRANSFER

I hereby authorize my Plan Service Provider (PSP) to facilitate Electronic Funds Transfer (EFT) between my Health Savings Account (HSA) and my Personal Bank Account as indicated below. These EFT transactions will be facilitated by the PSP but will be initiated by the Custodian. EFT transactions will be either a withdrawal from my Personal Bank Account for subsequent deposit into my HSA or will be a withdrawal from my HSA for subsequent deposit into my Personal Bank Account.

Account Type: Checking Account Savings Account
 Bank Name: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Bank Routing Number (First 9 numbers on bottom of check): _____
 Bank Account Number (Second set of numbers): _____

CUSTODIAN

National Advisors Trust Company, FSB
 10881 Lowell Avenue, Suite 100 • Overland Park, KS 66210

CUSTODIAL ACCOUNT MANAGER

DataPath Financial Services, Inc.
 P.O. Box 55068 • Little Rock, AR 72215
 Web: www.myHSAtoday.com • Email: info@myHSAtoday.com

PLAN SERVICE PROVIDER

Name: Alpha Benefit Administrators, LLC
 Serial Number (to be completed by PSP): _____

MARKETING REPRESENTATIVE

Name: _____
 Serial Number (to be completed by PSP): _____

OFFICIAL USE ONLY Account Number: _____ Date: _____
 Notes: _____ Signature: _____

Application & Beneficiary Designation Form

Please complete this Application & Beneficiary Designation Form and return to your Plan Service Provider (PSP) indicated on the back of this form.

ACCOUNT HOLDER INFORMATION (PLEASE PRINT) *REQUIRED FIELD

*Name: (First) _____ (MI) _____ (Last) _____

*Preferred Mailing Address: Home Address Mailing Address

*Home Address: _____

*City: _____ State: _____ Zip Code: _____

*Mailing Address (if different from above): _____

*City: _____ State: _____ Zip Code: _____

*Home Phone: _____ Work Phone: _____

Email Address: _____ *Date of Birth: _____

*Social Security Number: _____ *Driver's License Number: _____

*Mother's Maiden Name (security purposes only): _____ *City of Birth _____

EMPLOYER INFORMATION

Employer Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

ELIGIBILITY INFORMATION (YOU MUST CHECK YES ON EACH QUESTION BELOW TO BE ELIGIBLE FOR AN HSA)

- Yes No I am currently, or will be upon the date of my first contribution, an eligible individual as described in the Custodial Account Agreement.
- Yes No I understand that maintaining my eligibility is my responsibility and that the custodian will assume that all contributions are made while I am eligible to do so.
- Yes No I am currently, or will be upon the date of my first contribution, covered by a High Deductible Health Plan (HDHP) that meets the qualifications detailed in the Custodial Account Agreement.

HDHP INFORMATION

HDHP Carrier: _____ Check One: Single Coverage Family Coverage

Plan Effective Date: _____ Deductible Amount: \$ _____

ADOPTION AGREEMENT

This application is for the establishment of my individually owned Health Saving Account at the custodian displayed on the reverse side of this form. The information on this application is true and accurate to the best of my knowledge and I submit this form with full understanding and acceptance of the provisions contained within the Custodial Account Agreement, HSA Terms and Conditions Statement and the HSA Disclosure Statement. I also acknowledge that the Plan Service Provider (PSP) indicated on the reverse side of this form is authorized to perform transactions on my account and all such transactions initiated by the PSP should be treated as if initiated directly by me, the Account Holder. I agree and understand that during such time that I terminate employment and still own my Health Savings Account, until such time that my account is liquidated or transferred to another HSA Custodian, that an automatic monthly fee of \$5.00 per month will be deducted directly from my HSA account.

Signature of Account Holder: _____ Date: _____

(Beneficiary Designation on Opposite Side)