



Address for Return Mail:
Community State Bank
P.O. Box 79
802 E. Albion St.
Avilla, IN 46710-0079

Bank Use Only	
Checking Acct#	_____
Insurance Agent	_____
Phone Number	_____
HSA Solutions Customer ID#	_____

800-488-3958 * 260-897-3361 * Fax 260-897-2357 * Website: www.csbbankonline.com

HSA APPLICATION AND AGREEMENT

Today's Date _____

Name (first) (middle) (Last)			Soc. Sec. #		Date of Birth (xx-xx-xxxx format)	
Address			City		State	Zip
Home Phone ()		Mothers Maiden Name			Email	
Enclose photocopies of 1 form of I.D.						
Type of Initial Deposit						
Contribution Year: _____		Regular Amount \$ _____		Transfer (Attach Transfer Form) Amount \$ _____		Rollover (Attach Rollover Form) Amount \$ _____

The Patriot Act: 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 to you When you open an account we will ask for your name, street address, date of birth and other information that will allow us to identify you. We may ask to see your driver's license or other identifying documents.

APPLICATION AND AGREEMENT

Check One: Self-employed contributing with a personal check should choose Employee Contribution Self-employed contributing with a business check should Choose Employer Contribution.				<input type="checkbox"/> Employee initial Contribution Amount \$ _____	
				<input type="checkbox"/> Employer initial Contribution Amount \$ _____	
				<input type="checkbox"/> Total Initial Contribution Amount \$ _____	
Company Name			Contact Person		
Address		City		State	Zip Code
Phone Number ()		Fax Number ()		Email	

If you are married and choose anyone other than your spouse as primary beneficiary, you must complete and return HSA Beneficiary/Spousal consent form.

DESIGNATION OF BENEFICIARIES

The following individual (s) or entity shall be my primary and/or contingent beneficiary(ies). If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary beneficiary. If more than one primary beneficiary is designated and no distribution percentages are indicated, the beneficiaries will be deemed to own equal share percentages in the account. Multiple contingent beneficiaries with no share percentage indicated will also be deemed to share equally. If primary or contingent beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining beneficiary(ies) shall be increased on a pro-rated basis. If no primary beneficiary(ies) survive me, the contingent beneficiary(ies) shall acquire the designated share of my account. No tax or legal advice was given to me by the custodian or agent, I assume full responsibility for any adverse consequences.

Name & Address	Date of Birth	Social Security #	Relationship	Primary or Contingent	Share %

ELIGIBILITY REQUIREMENTS: REGULAR HSA

(Circle One)

Y N Account holder certification – I certify that: (1) I am covered by a qualified High Deductible Health Plan (HDHP), (2) I certify that I am not covered by a Health plan, other than HDHP, which provides any of the same benefits as the HDHP, (3) I am not entitled to benefits under Medicare, and (4) I may not Be claimed as a dependent on another person's tax return.

SHARED ACCOUNT NUMBER

(Circle One)

Y N I authorize HSA Solutions, LLC & Community State Bank to share my account number with my employer to facilitate HSA contribution.



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Health Plan Information (Choose one to complete) I have an individual Health Plan Deductible of \$ _____ I have a family Health Plan Deductible of \$ _____		
Health Insurance Company:	Section 125 plan – Pre-Tax ? Yes / No	Plan Effective Date:
Insurance Agent:	Insurance Agency:	Agent Phone Number: ()
Maximum yearly contribution for individuals is 100% of the annual deductible, not to exceed \$3,000.00. Maximum yearly contribution for a family is 100% of the annual deductible, not to exceed \$5,950.00.		

HSA ACCOUNT OPTIONS:

I would like to order 25 duplicate checks (1st order is free, then we will bill you for any additional checks ordered) to be used for normal distributions only.

I would like 1 free debit Visa issued in my name for my HSA account to be used for normal distributions only. (see below for additional card (s))

I would like 1 additional card.

Note: Purchases made with either my debit card or checks will be reported by the Bank as normal distributions. I understand I should not use my debit card or checks for non-qualifying or non-medical purposes and that I am responsible for any IRS penalties.

Optional: I hereby designate the following individual (s) as additional authorized signer (s) on my Health Savings Account to sign checks, and issue a separate debit Visa.
 To allow electronic access to my HSA.
 NOTE: If you are using an authorized signer for your HSA, your authorized signer must provide copies of 1 valid forms of ID as well.

Authorized Signer Printed Name	Authorized Signer Signature
Social Security No.	Date of Birth

Yes I would like to make Direct Deposits to my Health Savings Account. If "Yes" Please include a voided check from the account you wish to withdraw from.	Direct Deposit Amount \$ _____	Day of the Month
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Make check payable to **Community State Bank**:
 Opening Deposit: (\$50.00 Minimum) \$ _____

Send Check along with application and forms to:
Community State Bank Processing
 P.O. Box 79
 802 E. Albion St.
 Avilla, IN 46710-0079

Check order: (1st order free/additional \$ _____ orders \$9.60)

HEALTH SAVINGS ACCOUNT ADOPTION AGREEMENT

This Application, when signed by me and accepted by HSA Solutions, LLC, acting on behalf of Community State Bank, as Custodian, constitutes my adoption of the Community State Bank Health Savings Account Custodial Agreement (the "Custodial Agreement") and my acceptance of the terms thereof.

By signing this application, I acknowledge:

- 1). That my HSA has been established for the purpose of paying qualified medical expenses, and if distributions are not used for this purpose, I may be subject to ordinary income and penalty taxes, which I must report to the IRS.
- 2). That no loans may be taken from my HSA and no portion of my HSA may be used as security or collateral for a loan.
- 3). I am responsible for reporting my HSA and that HSA Solutions, LLC and Community State Bank has no duty to determine the investment, tax, or other consequences resulting from my actions involving my HSA.
- 4). That Community State Bank is not an insurance company who offers the high deductible insurance plans.
- 5). I will receive a copy of the HSA Custodial Agreement and Disclosure Statement in my Introduction Kit.
- 6). All fees are non-refundable.

BACK-UP WITHHOLDING CERTIFICATE

By signing below you certify under penalties of perjury:

- 1). The number shown on this form is my correct taxpayer identification number.
- 2). I am not subject to backup withholding either because I have not been notified that I am subject to backup withholding as a result of failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding. The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

Account Holder Sign Here X _____ Date _____
 031005



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HSA EMPLOYER CERTIFICATION

Accountholder Name: _____

To comply with the USA Patriot Act of 2001, the employer must verify the employee's identification, social security number, and address.

As a representative of _____(employer name), I verify the HSA participant named above is an active employee and his/her social security number and address are valid., and that they are the person on the ID.

Signature: _____ Date: _____

Print Name: _____

SUMMARY OF TYPES OF IDENTIFICATION

Should include picture, descriptions
signature and address

- *Valid driver's license
- *Valid non-driver's ID
- *Valid state or city employee ID
- *Valid passport
- *Alien registration
- *Armed forces ID card
- *Valid US Government ID

Primary identification – includes picture,
Description of person and signature.
May ask for additional forms of ID

NOTE: If you are using an authorized signer for your HSA, Your Authorized signer must provide copies of 1 valid forms of ID as well.