



Health Savings Account (HSA)

Application



In order to open a Health Savings Account ("HSA") through First Horizon MSAVER please complete this application. Please contact us at 1-866-889-8584 if you have any questions. Please mail the following to First Horizon MSAVER, P.O. Box 26106, Shawnee Mission, KS 66225.

- Your completed application
Initial HSA contribution of at least \$100.00 payable to First Horizon

PERSONAL INFORMATION

Title [] Mr. [] Mrs. [] Ms. [] Dr. Name (First) (MI) (Last)

Social Security Number (SSN) Date of Birth

Physical Address City State Zip

Mailing Address (if different from above) City State Zip

Work Phone Number Home Phone Number

Fax Number Email Address

USA PATRIOT ACT INFORMATION (required)

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.

Form of Identification [] Drivers License [] State ID [] Passport [] Military ID ID#

State of Issuance Date of Issuance Expiration Date Country(ies) of Citizenship

EMPLOYER INFORMATION

Company Name Human Resources Contact

Address City State Zip

Company Phone Number Your Occupation

HIGH DEDUCTIBLE HEALTH INSURANCE PLAN INFORMATION

Carrier Name Medical Mutual / CLIC Deductible Amount \$ [] Individual [] Family

Agent Name Agent Phone Number

Effective date of your coverage by a qualified, high-deductible health plan / /

PARTICIPANTS IN AN HSA CANNOT BE COVERED BY ANOTHER HEALTH PLAN EXCEPT "PERMITTED" INSURANCE PRODUCTS.

BENEFICIARY DESIGNATION (see next page for explanation)

Primary Beneficiary (ies)

Table with 6 columns: Name, Relationship, Social Security #, Date of Birth, Address, % (Must total 100)

Secondary Beneficiary (ies)

Table with 6 columns: Name, Relationship, Social Security #, Date of Birth, Address, % (Must total 100)

At the time of my death, the primary beneficiary(ies) named above will receive my HSA assets. If all of my primary beneficiaries die before me, the secondary beneficiary(ies) named above 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 in the same classification (i.e., primary, or secondary). If all of the beneficiaries die before me, my HSA assets will be paid to my estate. If no percentages are assigned to beneficiaries, the beneficiaries in the appropriate classification will share equally. If the percentage total for each beneficiary classification does not equal 100 percent, any excess or deficiency will be divided pro-rata among the beneficiaries within such classification. I understand that in certain states, my spouse's consent may be necessary if I wish to name a person other than, or in addition to, my spouse as beneficiary and that I should consult with an attorney before making such a beneficiary designation. By making the foregoing beneficiary designation, I represent and warrant to the Custodian that the beneficiary designation satisfies all legal requirements under applicable law and on behalf of myself, my heirs, and my estate, I hereby indemnify and hold the Custodian harmless from and against any and all claims, damages, liabilities and costs (including attorney's fees) arising as a result of the Custodian's payment of my HSA in accordance with the foregoing Beneficiary Designation.

AUTHORIZED SIGNERS (OPTIONAL)

Regulations require that only one individual own an HSA. An account holder may want a spouse, or another third party, to have access to funds within the HSA by naming them as an authorized signer. I (account holder) designate the following individual(s) as authorized signer(s) on my Health Savings Account. I understand these individuals will receive a Visa® debit card for use on this account.

First Signer

Name (First) _____ (MI) _____ (Last) _____ Date of Birth _____

Physical Address _____ City _____ State _____ Zip _____

Social Security Number (SSN) _____ Signature of Authorized Signer _____

Country(ies) of Citizenship _____ Occupation _____

Second Signer

Name (First) _____ (MI) _____ (Last) _____ Date of Birth _____

Physical Address _____ City _____ State _____ Zip _____

Social Security Number (SSN) _____ Signature of Authorized Signer _____

Country(ies) of Citizenship _____ Occupation _____

INITIAL HSA CONTRIBUTION Minimum Initial Contribution is \$100.00 (Make check payable to First Horizon).

Once you lose or terminate your Medical Mutual HDHP coverage the monthly administration fee of \$2.50 will be automatically debited from your account.

Initial HSA Contribution \$ _____ (For Tax Year 20 _____) Initial deposit made by Employer \$ _____ Individual \$ _____

Is this a rollover? Yes No In case of a rollover, you certify that this contribution is a rollover contribution within the meaning of Internal Revenue Code Section 223, that the rollover is being made within 60 days of receipt, and you have not received a rollover in the last 12 months.

Amount of rollover contribution \$ _____

INVESTMENT INFORMATION

Yes, I'm interested in receiving information about the investment options that are available with my HSA.

Yes, I want to open a Health Savings Account!

By signing below, I apply to open a Health Savings Account ("HSA") through First Horizon Msaver and certify that the information provided in this Application is correct. I understand that First Horizon Bank will be the Custodian for my HSA. I understand that you will send me the Depositors Agreement and Fee Schedule after my account is opened and that I will have seven (7) days from my receipt of those documents to revoke my account without penalty. I agree to be bound by all of the terms and conditions in the Depositors Agreement, the Custodial Agreement, and the Fee Schedule, as they may be amended by First Horizon Bank from time to time, unless I revoke my account within the time frame set forth above. Further, I understand that my Application is subject to acceptance by First Horizon Bank. I understand that the Visa® Debit Card is subject to the terms and conditions that are sent with the Card. I agree to pay all fees applicable to my HSA and authorize First Horizon Bank to deduct such fees from my HSA account. If I have completed the Beneficiary Designation section of this form, I direct that all funds remaining in any HSA at my death be paid to the Beneficiary(ies) as I have designated in that section of this form or in a new Beneficiary Designation that I may file prior to my death with the Custodian. This is a single ownership account in the name of the person identified in this Application, and only that person can designate or change beneficiaries on this account. I acknowledge and agree that First Horizon Bank is responsible for providing Custodial account services and First Horizon Msaver is responsible for providing administrative services including: enrollment assistance and documents which may be provided through Marketing Representatives, and access to the toll-free tax assistance help-line to answer any questions concerning Health Savings Accounts, tax-related matters, qualified medical expenses, or other distributions. I acknowledge that First Horizon Msaver does not provide investment advice and that all investment decisions and instructions regarding my Health Savings Account will be made solely by me upon consultation with my personal broker or investment advisor. First Horizon Bank and First Horizon Msaver are authorized to recognize my signature as set forth below, or the signature of any other person named in the Authorized Signers section of this Application, in the payment of checks or the transaction of any other business on this Account, any **one (1)** such signature or other authority being necessary. For verification purposes, I authorize First Horizon Msaver and First Horizon Bank to inform my insurance company and/or my insurance agent or broker that I have opened an HSA account and to inform my employer that I have opened an HSA account, the HSA account number, and the amount of employer contributions.

I have read and consent and agree to the terms of the Customer Agreement described above.

X

Customer Signature

Date

W-9 Under penalties of perjury, I certify that (1) the Social Security Number set forth below is my correct Taxpayer Identification Number (interest paid, if any, will be reported under this number), and that (2) I am exempt from backup withholding, or I am not subject to backup withholding as a result of a failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding, and (3) that I am a U.S. person (including a U.S. resident alien). Cross out item (2) above if you have been notified that you are subject to backup withholding because of underreporting of interest or dividends on your tax return.

Note: The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

X

Customer Signature

Date

Customer's Taxpayer ID #