HSA Enrollment Form and Agreements Administered by:

Health Savings Account Enrollment

INSTRUCTIONS

If you have any questions completing this form please contact First Horizon Msaver, Inc. at 1-866-889-8584.

Mail the following to: First Horizon Msaver, Inc., P.O. Box 26106, Shawnee Mission, KS 66225-9841

- Enrollment Form
- Custodial Agreement
- One Check for Initial HSA Deposit (Minimum $50; Payable to **National City Bank**)
- Signature Card
- Beneficiary Designation

Submit only after the effective date of your Qualified High Deductible Health Plan (QHDHP). Your HSA will not be opened until after the effective date of your QHDHP.

Upon approval of your application, you will receive the terms and conditions of your account.

Retain a copy of the enrollment form and custodial agreement for your records.

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 you: When you open an account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. In addition, all US persons will be required to provide a US Taxpayer Identification Number. We may also ask to see your driver's license or other identifying documents.

In all cases, protection of our customer's identity and confidentiality is National City's pledge to you.

APPLICANT INFORMATION

Title	First Name	MI	Last Name	Date of Birth	Social Security # (9 digits)
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.				/ /	– –

Home Address (No P.O. Box)	City	State	Zip

Telephone (Day)	Telephone (Evening)	Email

Mailing Address	City	State	Zip

Employer Name	Contact	Employer Telephone

Employer Address	City	State	Zip

Insurance Carrier Name	Agent Name	Telephone
Medical Mutual / CLIC		

Effective date of my qualified high deductible health plan (QHDHP) / /	Deductible Amount $ ☐ Individual ☐ Family

POWER OF ATTORNEY (POA) INFORMATION (Required for additional authorized CheckCard users)

Title	First Name	MI	Last Name	Date of Birth	Social Security # (9 digits)
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.				/ /	– –

Home Address (No P.O. Box)	City	State	Zip

The account owner may designate only one POA. The account owner and POA must complete the Consumer Signature Card.

INITIAL HSA CONTRIBUTION

Minimum Initial Deposit $50. *(Make Initial Deposit check payable to **National City Bank**.)*

Initial HSA Deposit	For Tax Year	Initial Deposit made by
$		☐ Employer $ ________ ☐ Individual $ ________

Is this a rollover?	Amount of rollover contribution	
☐ Yes ☐ No	$	**In the case of a rollover from an MSA or HSA, you certify that this contribution is a rollover contribution within the meaning of IRS 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.**

NATIONAL CITY CHECKCARD

☐ Check here if you want to be able to pay for qualified expenses by National City Visa CheckCard

☐ Check here if you want an additional CheckCard for your POA

If you checked either box, you authorize the bank to send you and/or your POA a CheckCard (Card) and a Personal Identification Number (PIN). You agree that each use of any Card and PIN shall be deemed authorization by you to the bank to charge or credit your accounts for the amount and types of transactions indicated at the time of use.

APPLICATION

By signing below, I am applying to open a Health Savings Account ("HSA") at National City Bank, Cleveland, Ohio ("National City"), and I acknowledge receipt of the National City Health Savings Account Custodial Agreement. I certify that all of the above information is true and complete, and I authorize National City to obtain information on my credit standing. I agree to be bound by all of the terms and conditions contained in said Custodial Agreement as it may be amended from time to time, as well as any rules or other terms issued by National City in connection with the HSA. Further, I understand that this Application Form is subject to acceptance by National City. I understand that my HSA will be subject to the National City Personal Account Agreement and Pricing Schedule for Health Savings Accounts which will be provided to me by National City when my HSA is opened. I agree to pay all fees applicable to my HSA and authorize National City to deduct such fees from my HSA. I acknowledge and agree that (i) only National City is responsible for providing HSA account services to me, (ii) First Horizon Msaver, Inc. shall not have any liability to provide, and will not provide, any such account services, (iii) National City does not provide administrative services such as enrollment assistance and documents, and access to the toll-free tax assistance help-line to answer any questions concerning health savings accounts, qualified medical expenses, or other distributions, (iv) any such administrative services provided to me will be provided solely by First Horizon Msaver, Inc. or others separate and apart from the account services provided by National City, and (v) National City does not have any control over, or liability for, administrative services provided by First Horizon Msaver, Inc. or others. **I agree that National City may provide information about my HSA to First Horizon Msaver, Inc. to be used solely for the purpose of providing me with the administrative services indicated above.** Any agency, appointment or authority that I may give to First Horizon Msaver, Inc. shall not apply to the HSA or any other account established at or by National City, and I agree that National City shall not honor or act upon any order, instruction, or other action or writing of First Horizon Msaver, Inc. purportedly acting as my agent or representative, whether to transfer my account or funds, take any other action with respect to my account, or otherwise. I agree that National City may require, as a condition of each transfer or requested action by it, that it first receive specific written instructions signed by me.

Applicant ______________________________ **Date:** ______________

FIRST HORIZON MSAVER CUSTOMER AGREEMENT

The following administrative services for my National City Health Savings Account ("HSA") are provided to me solely by First Horizon Msaver, Inc.: enrollment assistance and documents, which may be provided through a marketing representative; and access to the toll-free tax assistance help-line to answer any questions concerning Health Savings Accounts, tax-related matters and qualified medical expenses, and to initiate account maintenance or distributions.

As long as my Medical Mutual or CLIC Insurance is maintained and the administrative fee is paid by the insurance carrier, there is no monthly fee for my HSA Account. However, if for any reason the administrative fee is not paid by the insurance carrier, National City will assess my HSA a monthly administrative fee of $4.15 thereafter. By submitting this enrollment form, I agree to this monthly administrative fee. This monthly administrative fee is nonrefundable and is subject to change with 30 days' notice.

I understand and agree that National City Bank has no control over such administrative services and no obligation or liability with respect to administrative services. I acknowledge that First Horizon Msaver does not provide investment advice and that all investment decisions and instructions regarding my HSA will be made solely by me upon consultation with my personal broker or investment advisor. I hereby appoint and authorize First Horizon Msaver, Inc. as my designated agent to, with prior notice to me, transfer my HSA to another trustee or custodian designated by First Horizon Msaver, Inc., who will provide comparable or superior service, including a custodian who is affiliated with First Horizon Msaver, Inc. This appointment of First Horizon Msaver, Inc. as my designated agent is effective as of the date entered below and until revoked by me in writing. I have read and consent and agree to the terms of this First Horizon Msaver Administrative Services Agreement.

Customer Signature: ______________________________ **Date:** ______________

CUSTODIAL AGREEMENT

The account owner named above is establishing this health savings account (HSA) exclusively for the purpose of paying or reimbursing qualified medical expenses of the account owner, his or her spouse, and dependents. The account owner represents that, unless this account is used solely to make rollover contributions, he or she is eligible to contribute to this HSA; specifically, that he or she: (1) is covered under a high deductible health plan (HDHP); (2) is not also covered by any other health plan that is not an HDHP (with certain exceptions for plans providing preventive care and limited types of permitted insurance and permitted coverage); (3) is not enrolled in Medicare; and (4) cannot be claimed as a dependent on another person's tax return.

$ ____________ dollars in cash is assigned to this custodial agreement. The account owner and the custodian make the following agreement:

Article I

1. The custodian will accept additional cash contributions for the tax year made by the account owner or on behalf of the account owner (by an employer, family member or any other person). No contributions will be accepted by the custodian for any account owner that exceeds the amount for family coverage plus the catch-up contribution.
2. Contributions for any tax year may be made at any time before the deadline for filing the account owner's federal income tax return for that year (without extensions).
3. Rollover contributions from an HSA or an Archer Medical Savings Account (Archer MSA)(unless prohibited under this agreement) need not be in cash and are not subject to the maximum annual contribution limit set forth in Article II.

Article II

1. For calendar year 2005, the maximum annual contribution limit for an account owner with single coverage is the lesser of the amount of the deductible under the HDHP but not more than $2,650. For calendar year 2005, the maximum annual contribution limit for an account owner with family coverage is the lesser of the amount of the deductible under the HDHP but not more than $5,250. These limits are subject to cost-of-living adjustments after 2005. Eligibility and contribution limits are determined on a month-to-month basis.
2. Contributions to Archer MSAs or other HSAs count toward the maximum annual contribution to this HSA
3. For calendar year 2005, an additional $600 catch-up contribution may be made for an account owner who is at least age 55 and not enrolled in Medicare. The catch-up contribution increases to $700 in 2006, $800 in 2007, $900 in 2008 and $1,000 in 2009 and later years.
4. Contributions in excess of the maximum annual contribution limit are subject to an excise tax. However, the catch-up contributions are not subject to an excise tax.

Article III

It is the responsibility of the account owner to determine whether contributions to this HSA have exceeded the maximum annual contribution limit described in Article II. If contributions to this HSA exceed the maximum annual contribution limit, the account owner shall notify the custodian that there exist excess contributions to the HSA. It is the responsibility of the account owner to request the withdrawal of the excess contribution and any net income attributable to such excess contribution.

Article IV

The account owner's interest in the balance in this custodial account is nonforfeitable.

Article V

1. No part of the custodial funds in this account may be invested in life insurance contracts or in collectibles as defined in section 408(m).
2. The assets of this account may not be commingled with other property except in a common trust fund or common investment fund.
3. Neither the account owner nor the custodian will engage in any prohibited transaction with respect to this account (such as borrowing or pledging the account or engaging in any other prohibited transaction as defined in section 4975).

Article VI

1. Distributions of funds from this HSA may be made at any time upon the direction of the account owner.
2. Distributions from this HSA that are used exclusively to pay or reimburse qualified medical expenses of the account owner, his or her spouse, or dependents are tax-free. However, distributions that are not used for qualified medical expenses are included in the account owner's gross income and are subject to an additional 10 percent tax on that amount. The additional 10 percent tax does not apply if the distribution is made after the account owner's death, disability, or reaching age 65.
3. The custodian is not required to determine whether the distribution is for the payment or reimbursement of qualified medical expenses. Only the account owner is responsible for substantiating that the distribution is for qualified medical expenses and must maintain records sufficient to show that the distribution is tax-free.

Article VII

If the account owner dies before the entire interest in the account is distributed, the entire account will be disposed of as follows. If a beneficiary is named in the agreement, the balance of the account will pass to the named beneficiary as described below. If a beneficiary is not named or has pre-deceased the account owner, the account will pass to the estate of the account owner.

1. If the beneficiary is the account owner's spouse, the HSA will become the spouse's HSA as of the date of death.
2. If the beneficiary is not the account owner's spouse, the HSA will cease to be an HSA as of the date of death. If the beneficiary is the account owner's estate, the fair market value of the account as of the date of death is taxable on the account owner's final return. For other beneficiaries, the fair market value of the account is taxable to that person in the tax year that includes such date.

Article VIII

1. The account owner agrees to provide the custodian with information necessary for the custodian to prepare any report or return required by the IRS.
2. The custodian agrees to prepare and submit any report or return as prescribed by the IRS.

Article IX

Notwithstanding any other article that may be added or incorporated in this agreement, the provisions of Articles I through VIII and this sentence are controlling. Any additional article in this agreement that is inconsistent with section 223 or IRS published guidance will be void.

Article X

This agreement will be amended from time to time to comply with the provisions of the Code or IRS published guidance. Other amendments may be made with the consent of the persons whose signatures appear below.

Article XI

If the account owner dies and the beneficiary (whether or not named in the Agreement) is not the account owner's spouse, the HSA will cease (as described in Article VIII), the account will be closed and the amount will be distributed to the beneficiary.

National City®

HSA Beneficiary Designation

HSA Account Number	Social Security Number

I hereby revoke any Beneficiary Designation previously made by me and/or designate the following persons or trust to receive such sums as may become payable from the above-numbered Account in the event of my death.

SECTION I - Designation of Persons

Primary/Contingent Designation:
I hereby designate the following persons who survive me to receive the sums described below:

Name	Relationship	Share
	______ Spouse ______ Other	%

Address	City	State	Zip

Social Security Number	Date of Birth

Name	Relationship	Share
	______ Spouse ______ Other	%

Address	City	State	Zip

Social Security Number	Date of Birth

Contingent Designation (Optional)
If no primary Beneficiary is living at the time of my death, I designate the following persons who survive me to receive the sums described above:

Name	Relationship	Share
	______ Spouse ______ Other	%

Address	City	State	Zip

Social Security Number	Date of Birth

Name	Relationship	Share
	______ Spouse ______ Other	%

Address	City	State	Zip

Social Security Number	Date of Birth

***NOTE:** ADDITIONAL PRIMARY AND CONTINGENT BENEFICIARIES MAY BE DESIGNATED ON A SEPARATE, SIGNED PAGE.*

SECTION II - Designation of Trust As ______ Primary ______ Contingent

I hereby designate a certain trust identified as follows as Beneficiary of all sums payable from the Account in the event of my death:

Trust Name ______________________ Trust Address ______________________

SECTION III - General

Amounts payable at my death shall be distributed pursuant to the provisions of the HSA Custodial Agreement.

I expressly reserve my unconditional right to revoke this Beneficiary Designation. It may be changed only by my signing a new Beneficiary Designation and filing it with the Custodian, prior to my death. No divorce, marriage dissolution, separation or marriage annulment, whether occurring before or after the date of a beneficiary designation, shall have any effect upon any beneficiary designation, which shall remain in full force and effect until otherwise properly revoked or changed.

In determining the identity or existence of any spouse or Beneficiary, the Custodian shall be entitled to rely on an affidavit of the presumed spouse or Beneficiary or another person (including a trustee).

Signature	Date

Depositor's Name (Please print or type)

Please sign this form and submit it with your enrollment documents. If you are submitting this form to replace a previous Beneficiary Designation, please sign and return to National City, HSA Department, Loc.#16-0307, 770 W. Broad St., Columbus OH 43251

Date Received	Authorized Representative	Bank Number

HSA Signature Card

Certification: The Taxpayer Identification Number provided below will be used to report required information to the Internal Revenue Service. Under penalties of perjury, I certify that: (1) My correct TIN is ______________________________,
and (2) I am not subject to backup withholding either because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and (3) I am a U.S. person (including a U.S. resident alien).

(You must cross out item 2 if you have been notified by IRS that you are currently subject to backup withholding because you failed to report all interest and dividends on your tax return.)

___ I am a Non-Resident Alien (Complete W-8BEN)

Signature ______________________________ Date ______________________________

DEPOSITOR/LEGAL TITLE OF ACCOUNT

Date Opened	Date Revised	Account Number

CHECKING: Type of Account: HSA

☒ Personal

Depositor acknowledges receipt of the Personal Account Agreement, Pricing Schedule, Receipt and Rate Sheet, as applicable, completed, relative to the Account and agree to be bound thereby and by any amendments hereafter made. Depositor acknowledges that Bank is hereby given the right before or after the death of Depositor, to apply any balance in the Account to payment of any debit owing to Bank by Depositor.

SIGNATURE OF DEPOSITOR

Depositor ______________________________ Date ____________ ID Type Non-Documentary Iss N/A Exp N/A

Print Name ______________________________

APPOINTMENT OF POWER OF ATTORNEY (P.O.A)

Any deputy (P.O.A.) whose signature appears on this signature card is hereby authorized by Depositor to (1) endorse, cash or deposit checks or other items payable to Depositor, (2) withdraw funds from the Account, and (3) give instructions on any matter in connection with the Account. This power of attorney shall terminate as to Depositor when Bank receives written notice of termination from Depositor. Actual notice to Bank of the death of Depositor shall terminate this power of attorney. This power of attorney shall not be affected by the disability of Depositor.

Signature of P.O.A. ______________________________

Printed P.O.A. Name ______________________________

SIGNATURE OF DEPOSITOR IF POWER OF ATTORNEY IS DESIRED

Depositor ______________________________ Date ______________

Complete all lines indicated by an arrow.