HSA Plan Services provided by:
P.O. Box 493557 • Redding, CA 96049-3557
Toll Free: 877-313-7700 • Fax: 530-223-7719
Website: www.veritascdh.com

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.

Signature of Account Holder: ______________________ Date: ______________________

(Beneficiary Designation on Opposite Side)

VERITAS Health Systems

HSA Today — Save today for a healthy future

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: ______________________ Relationship: ______________________

Name: ______________________________ %: __________
Address: ______________________ City: ______________ State: ______ Zip: __________
SSN: ______________________ 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: ______________________ Relationship: ______________________

Name: ______________________________ %: __________
Address: ______________________ City: ______________ State: ______ Zip: __________
SSN: ______________________ Relationship: ______________________

Name: ______________________________ %: __________
Address: ______________________ City: ______________ State: ______ Zip: __________
SSN: ______________________ 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
Toll Free: 888-665-1264 • 501-687-1408
Web: www.myHSAtoday.com • Email: info@myHSAtoday.com

PLAN SERVICE PROVIDER

Veritas Health Systems
P.O. Box 493557 • Redding, CA 96049-3557
Toll Free: 877-313-7700 • Fax: 530-223-7719
Website: www.veritascdh.com

Serial Number: 728356662627

MARKETING REPRESENTATIVE

Name: ______________________________

Serial Number (to be completed by PSP): ______________________

OFFICIAL USE ONLY Account Number: ______________________ Date: __________

Notes: ______________________ Signature: ______________________

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HSA SALARY REDUCTION AGREEMENT

This Salary Reduction Agreement (SRA) authorizes your employer to reduce your salary by the indicated amount shown below for the exclusive purpose of facilitating a contribution to your Health Savings Account. **Do Not Send Contributions With This Form.**

HEALTH SAVINGS ACCOUNT ELIGIBILITY INFORMATION: In order to establish a Health Savings Account, you must be classified as an "Eligible Individual" under IRC Section 223, applicable sub-sections and rulings, collectively called the "Code". You are eligible for an HSA ***ONLY*** if you can meet the following requirements: (1) you are covered by a high deductible health plan ("HDHP"); (2) you are not covered by another health plan that is not a HDHP; (3) you are not able to be claimed as a dependent by another taxpayer; (4) you are not entitled to benefits under Medicare.

By completing this agreement, you are indicating that as of the effective date of your contribution election, you are an "Eligible Individual" as defined above and authorize your employer to facilitate your monthly contributions to your HSA on your behalf.

Instructions

Step 1 Complete the **PERSONAL INFORMATION** section. All information is required.
Step 2 Complete the **HSA CONTRIBUTION ELECTION** section with your total monthly contribution amount.
Step 3 Sign in the **SIGNATURES** section and return to your employer's designated person for processing.

PERSONAL INFORMATION

NAME: (please print) ____
(First) **(M.I.)** **(Last)**

DATE OF BIRTH: ____________________ **SOCIAL SECURITY NUMBER:** ____________________

EMPLOYER NAME: ____

HSA CONTRIBUTION ELECTION

I ELECT A MONTHLY CONTRIBUTION OF $ __________ **TO MY HSA EFFECTIVE** __________.
Amount Date

The monthly contribution amount may not exceed 1/12 of the annual deductible plus any Catch-Up contributions allowed.

Attention current MSA or HSA account holder with accounts at other financial institutions, please remember that the total annual contributions to all accounts may not exceed federally mandated limits.

SIGNATURES

Employee Signature: As of the effective date of my HSA Contribution Election, I certify that I am an "Eligible Individual" as defined by the Code and do hereby elect a Health Savings Account in accordance with Section 223 and Section 125 of the Internal Revenue Code. I understand this request will not be processed until all paperwork is completed, accepted and approved by my employer. I further understand that I am responsible for all contributions made to my HSA and that DataPath Administrative Services, Inc. is facilitating but not initiating the contribution.

Employee Signature: ______________________________ Date: ____________________

Employer Signature: The employee's election of the Health Savings Account Contribution is accepted as of the date shown below.

Authorized Signature: ______________________________ Date: ____________________

Plan Service Provider

Veritas Health Systems, P.O. Box 493557, Redding, CA, 94049-3557 **Serial Number: 728356662627**

PHONE: (877)313-7700 - FAX: (530) 223-7719 - WEB: www.veritascdh.com - E-MAIL: info@veritascdh.com

HSA DISTRIBUTION REQUEST FORM

Account Holder Information HSA Account Number: ___________________________

Name: ____ Distribution Amount: $________________________

Process my Distribution as a ___ **Direct Deposit** to my personal Checking or Savings Account on file or as a ___ **Check** and mailed to my home address.
For check distributions, a fee of $1.50 will apply and please allow appropriate time for 1st Class US Mail delivery.

_____ Check here if you want us to enter your medical claim information in the Electronic Claims Vault and process your actual HSA Distribution at a later time.

Please answer the following questions about this distribution from your HSA.

Is this distribution from your HSA for a Qualified Medical Expense? ___ Yes ___ No

If **Yes**, do you wish to provide medical information so that your Plan Service Provider may adjudicate and certify the medical expense? This is an optional service and is not required by HSA regulations.
___ Yes, I will supply the medical expense to the PSP for review and certification, see below for details
___ No, I will retain the medical expense information in my personal records and tax receipts
Note: if the medical information is not provided, your PSP cannot provide independent certification for this expense

If **No**, you understand that this distribution will be taxed as income (unless you have offsetting medical expenses) and may also be subject to an excise tax penalty of 10%. It is your responsibility to determine and report the tax consequences of this distribution.

Date of Service MM/DD/YY	Receipt Attached	Patient	Relationship	Provider	Description of Service	Amount
						$
						$
						$
						$
						$
					TOTAL	**$**

ACCOUNT HOLDER'S CERTIFICATION FOR DISBURSEMENT

I certify that this distribution requested from my accounts was incurred by me (and/or my spouse and/or eligible dependents), was not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible Section 213(d) medical expenses and should be treated as a Tax-Free Distribution under my HSA. I will not use the expense reimbursed through this account as deductions or credits when filing my individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature:____ **Date:** ________ /________ /________

FOR DISBURSEMENTS, FAX TO (530) 223-7719

OR MAIL TO: VERITAS HEALTH SYSTEMS, P.O. BOX 493557, REDDING, CA, 96049-3557

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