



Health Savings Account Packet

Please mail completed forms to:

Jones Bank
Attn: HSA Department
PO Box 469
Seward NE 68434-0469

402-643-3602 or 888-562-3602
Fax 402-643-3970
Member FDIC
www.jonesbank.com



Health Savings Account Checklist

To assure a smooth account opening, please use this handy checklist to be sure you have provided everything we need.

- ✓ **Complete the HSA Application and Eligibility form. The HSA Application must be signed in front of a Jones Bank Representative or Notary.**
- ✓ **If you are not a current customer of Jones Bank, we must obtain a Copy of the Drivers License, State ID, or Passport for each signer on the account (required by U.S. Patriot Act)**
- ✓ **Opening HSA contribution check (minimum of \$25.00) payable to Jones Bank. If your employer will be making automatic payroll deposits into your new HSA, no minimum deposit is required.**
- Once your application has been processed and accepted, you will receive a Visa® Debit Card and a complimentary pack of 50 checks in the mail (within 3 to 4 weeks). Additional checks can be purchased if needed.
- You or your employer can deposit money into your HSA. Your account earns tax-deferred interest.
- You pay health care expenses with your Visa® Debit Card or HSA checks.
- You receive monthly account statements from the Bank. Your statement itemizes deposits, withdrawals, and interest earned on your account.
- You claim your tax deduction. If you qualify for the federally tax-deferred HSA, you will claim the HSA deduction on your income taxes each year. The IRS form used for HSA's is Form 8853.
- Overdrafts of your HSA account may cause your HSA to be disqualified by the IRS. Any overdrafts are the responsibility of the account holder.

Call us if you have any questions at 402-643-3602 or toll-free at 1-888-562-3602.

Thank you for choosing Jones Bank when setting up your Health Savings Account. Jones Bank has been serving customers for over 135 years. All accounts are insured by the FDIC up to \$250,000.00.

HEALTH SAVINGS ACCOUNT APPLICATION AND ELIGIBILITY FORM

Instructions: All fields must be completed.
Return this Application and a check to:
Jones Bank, PO Box 469, Seward, NE 68434-0469

Make Check Payable to Jones Bank for:
Initial Contribution (min.\$25.00) \$ _____
If you have automatic deposits from your employer, no initial contribution is required.

Personal Information:

First Name _____ MI _____ Last Name _____

Street Address _____

Mailing Address (if different) _____

City _____ State _____ Zip Code _____

Home Phone # _____ Business/Cell Phone _____

Social Security # _____ Birth Date _____

Employer _____ US Citizen(Y/N) _____ Gender (M/F) _____

Occupation _____ No. of Years in Occupation _____

Mother's maiden name _____

Email Address _____

Include a copy of Driver's License, State ID or Passport

Type of initial Deposit – Please check one

Regular – Year of Contribution (required) _____

Rollover

Transfer

Initial Contribution Source and Amount

Account Holder Deposit Amt. \$ _____

Employer Deposit Amt. \$ _____

Plan Coverage Family _____ Single _____

Employer Information (for Employer deposits only)

Employer Name _____ Employer Contact Name _____

Mailing Address _____ Type of Business _____

City _____ State _____ Zip Code _____

Eligibility Requirements: REGULAR HSA

Yes No **Account holder certification-** I certify that: (1) I am covered by a Qualified High Deductible Health Plan (QHDHP), and (2) I certify that I am not covered by a health plan, other than a QHDHP, which provides any of the same benefits as the QHDHP.

If you answered NO to the above, you are not eligible to establish a qualified HSA. Please see your Insurance Agent to obtain a Qualifying High Deductible Health Plan. Upon completion of the eligibility requirements, you may complete the signature section of page two.

Health Savings Account Authorization

Custodian Authorization – I hereby appoint Jones Bank as my HSA custodian. Upon acceptance of my account, Jones Bank will open a variable interest rate checking account in the name of my HSA. A minimum \$25.00 deposit is required to open an account. The current interest rate of this account is stated in the *Truth In Savings Disclosure*. Interest will be accrued daily and compounded monthly by adding onto my HSA checking account. A monthly service fee of \$2.00 per month will be charged to accounts with balances less than \$500.00.

Checking and Visa® Debit Card Issuance – Upon receipt and processing of my HSA application, I will be mailed an initial book of 50 checks and deposit slips, in addition to a Visa® Debit Card. The checks and the Visa® Debit Card are to be used for payments of qualified medical expenses which will be reported at year end as qualified distributions from the account. **I am aware that I should not use the Visa® Debit Card or checks for non-qualifying or non-medical purposes and I am personally responsible for any IRS penalties or taxes that may apply.** Cash advances are not allowed with the HSA Visa® Debit Card.

Deposits – Any deposit made by me via deposit slips that I receive with my checks, internet transfers, EFT deposits, or ACH deposits will be considered current year contributions to my HSA. If I want to make a deposit to my HSA from January 1 thru April 15 of any year for a previous tax year, I must sign an *HSA Contribution Form* or talk to a Jones Bank HSA representative so the proper recording of the deposit is made.

Overdrafts – An overdraft may cause your HSA to be disqualified by the IRS. Any overdrafts are the total responsibility of the account holder.

Authorized Signer/Power of Attorney (Optional) A Copy of ID needed for all signers

Since regulations require that only one individual own an HSA, the account owner may want his/her spouse and/or another third party through power of attorney to write checks or use his/her Visa® Debit Card. I (account owner) hereby designate the following individual(s) as additional authorized signer(s) on my Health Savings Account. * *

* * * * *
First Name _____ MI _____ Last Name _____

Street Address _____

Mailing Address (if different) _____

City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone _____

Social Security # _____ Birth Date _____

Employer _____

Occupation _____ No. of Years in Occupation _____

Mother's maiden name _____

Email Address _____

Authorized Signer/POA Signature: _____ **Date** _____

Second Visa® Debit Card Option

I would like a Visa® Debit Card issued for the POA listed above for my HSA to be used for qualified medical expenses only. By signing this Application and per the HSA options selected above, I am requesting that the Bank issue to my spouse or other authorized third party as indicated above, a separate Visa® Debit Card to allow them electronic access to my Health Savings Account and to add their name to my checking account to facilitate access to my Health Savings Account.

USE THIS PAGE ONLY FOR AN ADDITIONAL 3RD SIGNER

Authorized Signer/Power of Attorney (Optional) A copy of ID needed for all signers

Since regulations require that only one individual own an HSA, the account owner may want his/her spouse and/or another third party through power of attorney to write checks or use his/her Visa® Debit Card. I (account owner) hereby designate the following individual(s) as additional authorized signer(s) on my Health Savings Account. * *

* * * * *

First Name _____ MI _____ Last Name _____

Street Address _____

Mailing Address (if different) _____

City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone _____

Social Security # _____ Birth Date _____

Employer _____

Occupation _____ No. of Years in Occupation _____

Mother's maiden name _____

Email Address _____

Authorized Signer/POA Signature: _____ **Date** _____

Third Visa® Debit Card Option

I would like a Visa® Debit Card issued for the POA listed above for my HSA to be used for qualified medical expenses only. By signing this Application and per the HSA options selected above, I am requesting that the Bank issue to my spouse or other authorized third party as indicated above, a separate Visa® Debit Card to allow them electronic access to my Health Savings Account and to add their name to my checking account to facilitate access to my Health Savings Account.

Designation of Beneficiary

Please initial one of the lines below

_____ In the event of my death, pay my HSA balance to the following primary beneficiary(ies). If all of the primary beneficiaries die before me, pay my HSA balance to the contingent beneficiary(ies). If any of my beneficiaries die before me, the deceased beneficiary's share will be reallocated among the surviving beneficiaries on a prorata basis. If none of the beneficiaries survive me, any balance in my HSA will be paid to my estate. OR

_____ In the event of my death, pay my HSA balance to the following primary beneficiary(ies). If all of the primary beneficiaries die before me, pay my HSA balance to the contingent beneficiary(ies). If any of my beneficiaries die before me, the deceased beneficiary's share will be allocated to the contingent beneficiary's children per stirpes representation basis. (The share passes to his/her living children.)

A. Primary Beneficiary(ies)

PERCENTAGE	NAME OF BENEFICIARY CITY AND STATE	SSN OR TIN	RELATIONSHIP	DATE OF BIRTH

B. Contingent Beneficiary(ies)

PERCENTAGE	NAME OF BENEFICIARY CITY AND STATE	SSN OR TIN	RELATIONSHIP	DATE OF BIRTH

Signatures **Important: Please read before sign**

I acknowledge that my HSA is my sole responsibility and that the Custodian shall have NO LIABILITY for any loss, damage, or tax, including a prohibited transaction tax or plan disqualification tax, resulting from transactions executed by the Custodian based on directions received from me. I agree to hold the Custodian harmless for its actions hereunder which were directed by me and will indemnify the Custodian for any and all claims and costs arising from transactions executed by the Custodian based on directions received from me, including but not limited to, court costs, attorney fees and other expenses incurred. I understand the eligibility requirements for the type of HSA deposit I am making and I state that I do qualify to make the deposit. I have received a copy of the Application and the HSA Custodial Agreement. I understand that the terms and conditions which apply to this HSA are contained in the Application and the Agreement. I agree to be bound by those terms and conditions. Within seven (7) calendar days from the date I open this HSA I may revoke it by mailing or delivering a written notice to the custodian of the account.

I assume complete responsibility for:

- 1. Determining that I am eligible for an HSA each year I make a contribution.**
- 2. Ensuring that all contributions I make are within the limits set forth by the tax laws.**
- 3. The tax consequences of any contribution (including rollovers) and distributions.**

T.I.N. BACKUP WITHHOLDING CERTIFICATION (Cross out item two (2) if subject to backup withholding)

Under penalties of perjury, I certify that (1) The number shown on this form is my correct taxpayer identification number (T.I.N.)(or I am waiting for a number to be issued to me), (2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest and 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). The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

HSA Owner Signature

Date

Jones Bank Representative Signature

Date

or

(S E A L)

Notary

Date

YOUR DEPOSIT ACCOUNT TERMS AND CONDITIONS

AGREEMENT - These terms govern the operation of this account unless varied or supplemented in writing. Unless it would be inconsistent to do so, words and phrases used in this document should be construed so that the singular includes the plural and the plural includes the singular. As used in this form, the words "we," "our," or "us" mean the financial institution and the words "you" or "your" mean the account holder. "Party" means a person who, by the terms of an account, has a present right, subject to request, to payment from the account other than as a beneficiary or agent. This account may not be transferred or assigned without our written consent.

Much of our relationship with our deposit customers is regulated by state and federal law, especially the law relating to negotiable instruments, the law regulating the methods of transferring property upon death and the rights of surviving spouses and dependents, the law regarding the availability of deposited funds. This body of law is too large and complex to be reproduced here.

The purpose of this form is to summarize the rules applicable to the more common transactions and to establish rules for certain events or transactions with the law already regulates but permits variation by agreement. We may permit some variations from this standard agreement, but any such variations must be agreed to in writing either on our signature card for the account or in some other written form.

LIABILITY – Each of you agrees, for yourself (and the person you represent if you sign as a representative of another) to the terms of this account and the schedule of charges that may be imposed. You authorize us to deduct these charges as accrued directly from the account balance. You also agree to pay additional reasonable charges we may impose for services you request which are not contemplated by this agreement. Each of you also agrees to be jointly and severally liable for any account deficit resulting from charges or overdrafts, whether caused by you or another authorized to withdraw from this account, and the costs we incur to collect the deficit including, to the extent permitted by law, our reasonable attorney's fees.

DEPOSITS – Any items, other than cash, accepted for deposit (including items drawn "on us") will be given provisional credit only until collection is final (and actual credit for deposits of, or payable in, foreign currency will be at the exchange rate in effect on final collection in U.S. dollars). We are not responsible for transactions initiated by mail or outside depository until we actually record them. All transactions received after our "daily cut-off time" on a business day we are open, or received on a day in which we are not open for business, will be treated and recorded as if initiated on the next following business day that we are open.

WITHDRAWALS – Unless otherwise clearly indicated on the account records, any one of you who signs this form including authorized signers, may withdraw all or any part of the account balance at any time on forms approved by us. You (until we receive written notice to the contrary) authorize each other person signing this form to endorse any item payable to you or your order for deposit to this account or any other transaction with us. We may charge against your account a check, even though payment was made before the date of the check, unless you have given us written notice of the postdating. The fact that we may honor withdrawal requests which overdraw the finally collected account balance does not obligate us to do so, unless required by law. Withdrawals will first be made from collected funds, and we may, unless prohibited by law or our written policy, refuse any withdrawal request against uncollected funds, even if our general practice is to the contrary. We reserve the right to refuse any withdrawal or transfer request which is attempted by any method not specifically permitted. Even if we honor a nonconforming request, repeated abuse of the stated limitations (if any) may eventually force us to close this account. On interest-bearing accounts other than time deposits, we reserve the right to require at least seven days' written notice before any withdrawal or transfer.

ACH AND WIRE TRANSFERS – This agreement is subject to Article 4A of the Uniform Commercial Code in the state in which you have your account with us. If you originate a fund transfer for which Fedwire is used, and you identify by name and number a beneficiary financial institution, an intermediary financial institution or a beneficiary, we and every receiving or beneficiary financial institution may rely on the identifying number to make payment. We may rely on the number even if it identifies a financial institution, person or account other than the one named. You agree to be bound by automated clearing house association rules. These rules provide, among other things, that payments made to you, or originated by you, are provisional until final settlement is made through a Federal Reserve Bank or

payment is otherwise made as provided in Article 4A-403(a) of the Uniform Commerce Code. If we do not receive such payment, we are entitled to a refund from you in the amount credited to your account and the party originating such payment will not be considered to have paid the amount so credited. If we receive a credit to an account you have with us by wire or ACH, we are not required to give you any notice of the payment order or credit.

OWNERSHIP OF ACCOUNT – You intend these rules to apply to this account depending on the form of ownership and beneficiary designation, if any, specified on the Health Savings Account Application. We make no representations as to the appropriateness or effect of the ownership and beneficiary designations, except as they determine to whom we pay the account funds.

RIGHTS AT DEATH – Single Party Account – At death of party, ownership passes as part of party's estate. **Single Party Account with POD (Pay-on-Death) Designation** – At death of party, ownership passes to POD Beneficiaries and is not part of party's estate.

STOP PAYMENTS – A stop-payment order must be given in the manner required by law and must be received in time to give us a reasonable opportunity to act on it before our stop-payment cut-off time. Our stop-payment cut-off time is one hour after the opening of the next banking day after the banking day on which we receive the item. Additional stop-payment order must precisely identify the number, date and amount of the item, and the payee. We will honor a stop-payment request by the person who signed the particular item, and, by any other person, even though such other person did not sign the item, if such other person has an equal or greater right to withdraw from this account than the person who signed the item in question. A release of the stop-payment request may be made only by the person who initiated the stop-payment.

AMENDMENTS AND TERMINATION – We may change any term of this agreement. Rules governing changes in interest rates have been provided separately. For other changes we will give you reasonable notice in writing or by any other method permitted by law. We may also close this account at any time upon reasonable notice to you and tender of the account balance personally or by mail.

STATEMENTS – You must examine your statement of account with "reasonable promptness." If you discover (or reasonably should have discovered) any unauthorized payments or alterations, you must promptly notify us of the relevant facts. If you fail to do either of these duties, you will have to either share the loss with us, or bear the loss entirely yourself (depending on whether we exercised ordinary care and, if not, whether we substantially contributed to the loss). The loss could be not only with respect to items on the statement but other items forged or altered by the same wrongdoer. You agree that the time you have to examine your statement and report to us will depend on the circumstances, but that such time will not, in any circumstance, exceed a total of 30 days from when the statement is first made available to you.

You further agree that if you fail to report any unauthorized signatures, alterations, forgeries or any other errors in your account within 60 days of when we make the statement available, you cannot assert a claim against us on any items in that statement, and the loss will be entirely yours. This 60 day limitation is without regard to whether we exercised ordinary care. The limitation in this paragraph is in addition to that contained in the first paragraph of this section.

DIRECT DEPOSITS – If, in connection with a direct deposit plan, we deposit any amount in this account which should have been returned to the Federal Government for any reason, you authorize us to deduct the amount of our liability to the Federal Government from this account or from any other account you have with us, without prior notice and at any time, except as prohibited by law. We may also use any other legal remedy to recover the amount of our liability.

AUTHORIZED SIGNER/POWER OF ATTORNEY – Authorized signers and Power of Attorney's may make account transactions on behalf of the parties, but have no ownership or rights at death unless named as Pay-on-Death beneficiaries.

RESTRICTIVE LEGENDS – We are not required to honor any restrictive legend on checks you write unless we have agreed to the restriction in writing signed by one of our officers. Examples of restrictive legends are "must be presented with 90 days" or "not valid for more than \$1000"

I:/T-WORD/IRA/Health Savings Account.doc