JonesBank

Main Bank
203 S 6th St
Seward, NE 68434
402-643-3602

Milford Branch
807 5th St
Milford, NE 68405
402-761-3602

Valparaiso Branch
108 W 2nd St
Valparaiso, NE 68065
402-784-2200

HEALTH SAVINGS ACCOUNT APPLICATION AND ELIGIBILITY FORM

Account Number _____ (Assigned by Bank after completion)

Instructions: All fields must be completed. Return this Application and a check to: Jones Bank, PO Box 469, Seward, NE 68434 or email to trust@jonesbank.com	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 _____

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 three.

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.

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

9-2022