

Each applicant opening an HSA must complete this form and **attach a photocopy of their valid Drivers License, State Issued I.D. or Passport** enlarged at least 125% of its original size.



All HSA accounts must be opened as an **individual** account even if the HDHP is for family coverage.

**HEALTH SAVINGS ACCOUNT  
WORKSHEET**

New HSA    Transfer from existing HSA    Rollover from Archer Medical Savings

**EMPLOYEE INFORMATION**

Type of Coverage:    Single    Family

(Please type or print all information)

Name: Last	First	MI
Address		
City	State	Zip
Social Security Number		Date of Birth
Employer (business name)		Home Phone
Business Phone	Driver's License State and #	
Email Address		

**\*PRIMARY BENEFICIARY** (Percentages must total 100%)

1. _____ % To Name: _____	Relationship: _____
Address: _____	Social Security # _____
City, State, Zip: _____	Date of Birth: _____

2. _____ % To Name: _____	Relationship: _____
Address: _____	Social Security # _____
City, State, Zip: _____	Date of Birth: _____

3. _____ % To Name: _____	Relationship: _____
Address: _____	Social Security # _____
City, State, Zip: _____	Date of Birth: _____

**\*CONTINGENT BENEFICIARY** Please list additional Contingent Beneficiary Info on back if needed

(Percentages must total 100%)

1. _____ % To Name: _____	Relationship: _____
Address: _____	Social Security # _____
City, State, Zip: _____	Date of Birth: _____

\*At your death HSA funds will be divided among the Primary Beneficiaries as designated. If all of the Primary Beneficiaries predecease you the Contingent Beneficiaries will receive the funds. If no beneficiaries are named or are living at the time of your death, the funds will go into your estate.

**Check to receive the following services:**

- Internet Banking to view my account    TeleBanker for balance information  
 Debit Card    HSA Checks    Payroll Direct Deposit-Opening Deposit Amt. \$ \_\_\_\_\_

As the account owner, I designate the following individual as an additional authorized signer/attorney-in-fact for normal distributions only. Please issue them an additional debit card. **(Copy of drivers license, State I.D. or passport must be attached)**

Name: _____	Relationship _____
Address: _____	Social Security # _____
City, State, Zip: _____	Date of Birth: _____

**I understand First Federal may verify my identification information with a national credit bureau.**

Account Owner Signature \_\_\_\_\_ Date \_\_\_\_\_

Authorized Signer/Attorney-in-Fact Signature \_\_\_\_\_ Date \_\_\_\_\_

<p><b>For Vendor/Agency Use (if applicable):</b>  Vendor/Agent Name: <b>David Lowe Ins. Agency</b>      Vendor/Agent #: <b>128141</b></p>
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