AMERICAN FIDELITY
a different opinion

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Oklahoma City, OK 73125
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Local: (405) 523-5699
Fax: (844) 560-6754
Website: www.afhsa.com
Email: afhsa_receipts@alegeus.com

HEALTH SAVINGS ACCOUNT
Application and Custodial Agreement

PLEASE NOTE: Do not use a coversheet if faxed. Fax will go into secured inbox. Bar code must be visible on first page for processing.

PERSONAL INFORMATION					
Name			SSN		
Physical Address			DOB (mm/dd/yyyy)		
City, State, Zip			Marital Status	☐ Single	☐ Married
Mailing Address (if different)			Driver's License #		
City, State, Zip			Issuing State		
Home Phone		Work Phone		Cell Phone	
Email address					

Important Information about Procedures for Opening a New Account:

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. We may also ask to see your driver's license or other identifying documents.

HEALTH PLAN INFORMATION					
■ Yes ☐ No	Are you covered by an HSA qualified high deductible plan (HDHP)? (If you answer no, you are not eligible to establish an HSA.)			☐ Yes ☐ No	Are you covered by any other non-permitted health plan? (See www.afhsa.com for definitions & examples)
Carrier Name				☐ Yes ☐ No	Are you covered by Medicare?
Effective date of HDHP	_____	Yearly Deductible	$_____	☐ Yes ☐ No	Are you claimed as a dependent on another person's tax return?
Type of Coverage	■ Individual ☐ Family			(If you answered yes to any of the questions above, you are not eligible to establish an HSA. See IRS Publication 969 for specific information.)	

EMPLOYER INFORMATION (if you are establishing the HSA separate from your employer, this information does not need to be completed)			
Company Name	MSD of Decatur Township Schools	Contact	Benefits Coordinator
Address	5275 Kentucky Ave	Telephone Number	(317) 856-5265
City, St, Zip	Indianapolis	Date of Employment	

CONTRIBUTION INFORMATION

Requested effective date for the HSA: _____

(The requested effective date cannot be sooner than the date this application is signed, effective date of coverage under the HDHP or the date you are eligible to contribute to an HSA.)

Contribution	Annual	Per Pay Period	Pay Period (if applicable)
Employer	$_____	$_____	☐ Monthly ☐ Bi-monthly ☐ Weekly ☐ Bi-weekly
Individual	$_____	$_____	
Catch-up Contribution	$_____	$_____	

[2017] Maximum Annual Contribution: Individual = [$3,400] Family = [$6,750]

[2018] Maximum Annual Contribution: Individual = [$3,450] Family = [$6,900]

For additional information on what may affect your annual allowable contribution(s), please visit www.afhsa.com.

Account owners age 55+ may make an additional contribution of $1,000/year.

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REQUEST FOR ADDITIONAL DEBIT CARD (Optional)			
Would you like a second debit card for use by an authorized user – either a spouse or an eligible dependent*- at no additional fee? ☐ Yes ☐ No *Dependent must be 18 years or older.			
Name		Relationship	
Social Security #		DOB (mm/dd/yyyy)	
☐ Check this box if you would like to list the above person as a signatory on your HSA.			
A MasterCard will automatically be mailed to your home address shown above. The debit card can be used with merchants with a valid medical merchant code. By requesting a secondary debit card, you are agreeing that the secondary debit card is subject to the HSA custodial agreement, all other conditions of the account, and all law governing HSA accounts.			

BENEFICIARY INFORMATION					
Name		Relationship		☐	Primary
Address		DOB		☐	Contingent
City, St, Zip				____%	Percent
Name		Relationship		☐	Primary
Address		DOB		☐	Contingent
City, St, Zip				____%	Percent
Name		Relationship		☐	Primary
Address		DOB		☐	Contingent
City, St, Zip				____%	Percent

Back-Up Withholding Certificate

I hereby certify under penalties of perjury that: The social security number shown on this form is my correct taxpayer identification number, I am a U.S. person (including a U.S. resident alien), and that (please check the appropriate box):

☐ I am not subject to 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 or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

☐ I am subject to backup withholding.

This application, when signed by me and accepted by American Fidelity Health Services Administration - Administrator/Record keeper, constitutes my adoption of this application/Custodial Agreement. By signing this agreement, I acknowledge and certify that I have received either in print or electronically (available anytime at www.afhsa.com), read and agree to the terms in the HSA Custodial Agreement, HSA Interest & Fee Schedule and Terms and Conditions of my Account and any amendments thereof.

_____ _____ _____ _____

Signature of Depositor | Date | Signature of Custodian | Date