Toll Free: (800) 662-1113
Fax: (844) 560-6754
P.O. Box 258886
Oklahoma City, OK 73125
Website: americanfidelity.com
Email: WG-AcctAdmin-HSA@americanfidelity.com

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HEALTH SAVINGS ACCOUNT (HSA) APPLICATION

PERSONAL INFORMATION					
Name*			SSN*		
Physical Address*			DOB (mm/dd/yyy)*		
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: *** Required fields**

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. When you open an HSA, 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. Your identity may be verified through the use of a database maintained by a third party. If your identity cannot be verified, you may be asked to provide additional information or your HSA may be closed. Upon such closure, funds deposited in your HSA will be returned, and we shall not be liable for any tax consequences of transfer or distribution of your assets as a result of this distribution. If additional debit cards are requested, the same procedures apply to those individuals.

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 (i.e. Health FSA, spouse's non-HDHP medical plan)?
Carrier Name	ANTHEM BLUE CROSS BLUE SHIELD			☐ 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			
Company Name*	WASHOE COUNTY SCHOOL DISTRICT	Contact	BENEFITS DEPARTMENT
Address	425 E. NINTH STREET	Telephone Number	775-348-0321
City, State, Zip	RENO, NV 89512	Date of Employment	

CONTRIBUTION INFORMATION

Requested effective date for the HSA: _____

(The requested effective date cannot be before 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	Annual maximums are updated each year by the IRS. For additional information on what may affect your annual allowable contribution(s) or to find out the allowable maximum contribution amount, please log in to your online account and review the details under "Resources"
Individual	$_____	$_____		
Catch-up Contribution	$_____	$_____		

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REQUEST FOR BENEFITS DEBIT CARD

Would you like a Benefits Debit Card to use with your HSA? ☐ Yes ☐ No

Would you like an additional card for use by an authorized user – either a spouse or an eligible dependent*? ☐ Yes ☐ No

*Dependent must be 18 years or older. **Required field for additional card.

Name**		Relationship	
SSN**		DOB (mm/dd/yyyy)**	

A MasterCard® issued by The Bancorp Bank (Member FDIC) (pursuant to a license from MasterCard International) will be mailed to your address shown above, and will contain your Benefits Debit Card and a Cardholder Agreement for your review and review by any additional cardholder. This card will "stack" with other reimbursement accounts you may have through American Fidelity so that all accounts will be included on the single card. If you already have a Benefits Debit Card, you will use that card for the HSA as well, and you will not receive a separate card for the HSA.

BENEFICIARY INFORMATION

Name		Relationship		☐	Primary
Address		DOB		☐	Contingent
City, St, Zip		SSN		____%	Percent
Name		Relationship		☐	Primary
Address		DOB		☐	Contingent
City, St, Zip		SSN		____%	Percent
Name		Relationship		☐	Primary
Address		DOB		☐	Contingent
City, St, Zip		SSN		____%	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.

Consent to Receive Electronic Notices

In order to apply for an HSA, you must consent to receive documents and notices related to your HSA in electronic form. Your consent will apply both at the time of enrollment and in the future. The documents and notices you agree to receive in electronic form include the following: enrollment forms, Health Savings Account (HSA) Custodial Agreement; disclosures relating to Truth in Savings and funds availability policies; American Fidelity Assurance Company privacy policy; documents issued by mutual fund and insurance companies, including prospectuses and trade confirmations; IRS Tax Forms 1099-SA and 5498-SA; account summaries; and confirmation of your online or telephonic instructions or elections. **Your consent will continue to apply until you are no longer an accountholder or until you withdraw consent as provided below.**

If you wish to withdraw your consent to electronic delivery of notices, you may call Customer Service at (800) 662-1113. Confirmation of your withdrawal will be in writing (electronically or on paper). Additional fees may apply for paper copies of applicable notices (see fee schedule). Investment options may not be available if you do not consent to receive prospectuses, trade confirmations and related documents in electronic form. We reserve the right to close your account if you withdraw your consent to electronic delivery of notices.

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Certification

I certify that I qualify to have a Health Savings Account (HSA) and that I have authorized my Employer to deliver funds withheld from my paycheck to American Fidelity for American Fidelity to deposit to my HSA. If I request to make a deposit to my HSA outside of payroll deduction, I expressly authorize American Fidelity to debit the account I specify and transfer funds to my HSA (and if necessary, to electronically credit my account to correct erroneous debits). I will enter additional details for each transaction within my online account. I understand that the amount I can contribute must be in accordance with IRS contribution limits (see IRS Publication 969, "Health Savings Accounts and Other Tax-Favored Health Plans," available at www.irs.gov).

By instructing American Fidelity Assurance Company to open the HSA, contributing funds to the HSA or otherwise using the HSA, I acknowledge that I have reviewed and consent to the terms of the Health Savings Account Custodial Agreement, which includes all cash, investment and other supplemental terms and conditions referenced therein.

_____ Signature of Account Holder

_____ Date

This application will be null and void if altered in any way.