ALLIANT credit union

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HEALTH SAVINGS ACCOUNT (HSA) - APPLICATION AND REVOCABLE DESIGNATION OF BENEFICIARY(IES)

HSA owner's name (member):	**member account no.:**
Address:	**daytime phone no.:**
	social security no.:
Country:	**date of birth:**

Please indicate your High Deductible Health Plan coverage level: ☐ **Individual or** ☐ **Family**

_____ _____ **if covered by your High Deductible Health Plan**.

Spouse first and last name **birth date**

PRIMARY BENEFICIARY(IES)

If you name more than one primary beneficiary, use the % column to indicate the percentage each is to receive. The total must equal 100%.

%	print name	address, city, state, zip code	relationship	birthdate

SECONDARY BENEFICIARY(IES)

If you name more than one secondary beneficiary, use the % column to indicate the percentage each is to receive. The total must equal 100%.

%	print name	address, city, state, zip code	relationship	birthdate

See HSA Custodial Agreement for further information Please indicate if you have a spouse ☐ Yes ☐ No

==========**CONSENT OF SPOUSE**==========

I consent to the designation of beneficiary(ies) on this form. I also waive all my rights to this HSA under community property laws, except to the extent of my interest under the designation of beneficiary(ies) on this form. I understand that I may not revoke this consent in the future. However, this waiver of my rights will terminate if my spouse (OWNER) amends this designation of beneficiary(ies) without my consent during my lifetime.

_____ _____

signature of owner's spouse date

If your spouse is not named as a primary beneficiary with at least 50% allocation of HSA funds, then have spouse sign **CONSENT OF SPOUSE**.

==========**HSA OWNER'S SIGNATURE**==========

I am establishing this Health Savings Account (HSA) exclusively for the purpose of paying or reimbursing my qualified medical expenses and those of my spouse and dependents. I represent that, unless this account is used solely to receive direct transfer or rollover contributions, I am eligible to contribute to this HSA; specifically: (1) I am covered under a qualified high deductible health plan (HDHP), (2) I am not also covered by any other health plan that is not an HDHP (with certain exceptions for plans providing preventive care and limited types of permitted insurance and permitted coverage), and (3) I am not enrolled in Medicare. I acknowledge receipt of the "Credit Union HSA Disclosure Statement." I also accept the terms and conditions of the "Credit Union HSA Custodial Agreement."

_____ _____

HSA owner's signature (member) date

ACCEPTANCE OF CUSTODIAN

Alliant Credit Union hereby acknowledges receipt of this application and does hereby establish a Health Savings Account for the above HSA owner under terms and conditions of the Credit Union HSA Custodial Agreement.

_____ _____

credit union representative's authorized signature date

RETURN COMPLETED FORM TO ALLIANT CREDIT UNION - FAX: 773-462-8735

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