



Application and Beneficiary Designation Form

Please complete this form and return to your Plan Service Provider (PSP) indicated on the back of this form.

Account Holder Information (Please Print)

*Required Field

*Name: (First) _____ (MI) _____ (Last) _____

*Preferred Mailing Address: Home Address Mailing Address

*Home Address: _____

*City: _____ State: _____ Zip Code _____

*Mailing Address (if different from above): _____

*City: _____ State: _____ Zip Code _____

*Home Phone: _____ Work Phone: _____

*Social Security Number: _____

*Mother's Maiden Name (security purposes only): _____ *City, State of Birth: _____

Employer Information

Employer Name: Siloam Springs School District

Address: PO Box 798

City: Siloam Springs State: AR Zip Code 72761

Is your HSA funded through Cafeteria Plan deductions? Yes No

Eligibility Information (You Must Check Yes On Each Question Below To Be Eligible For An HSA)

- Yes No I am currently, or will be upon the date of my first contribution, an eligible individual as described in the Custodial Account Agreement.
- Yes No I understand that maintaining my eligibility is my responsibility and that the Custodian will assume that all contributions are made while I am eligible to do so.
- Yes No I am currently, or will be upon the date of my first contribution, covered by a High Deductible Health Plan (HDHP) that meets the qualifications detailed in the Custodial Account Agreement.

HDHP Information

HDHP Carrier: _____ Check One: Single Coverage Family Coverage

Plan Effective Date: _____ Deductible Amount: \$ _____

HSA Contribution Election

I elect a payroll contribution of \$ _____ (amount) Deducted every: _____ (Monthly, Bi-Weekly, Semi-Monthly, Weekly) Effective on or after: _____ (mm/dd/yyyy)

Adoption Agreement

This application is for the establishment of my individually owned Health Saving Account at the Custodian displayed on the reverse side of this form. The information on this application is true and accurate to the best of my knowledge and I submit this form with full understanding and acceptance of the provisions contained within the Custodial Account Agreement, HSA Terms and Conditions Statement and the HSA Disclosure Statement. I also acknowledge that the Plan Service Provider (PSP) indicated on the reverse side of this form is authorized to perform transactions on my account and all such transactions initiated by the PSP should be treated as if initiated directly by me, the Account Holder.

Signature of Account Holder: _____ Date: _____

(Beneficiary Designation on Opposite Side)



Application and Beneficiary Designation Form (cont.)

Pursuant to Section VI of the Custodial Account Agreement, you are authorized to designate one or more individuals as your Account Beneficiary(ies). For each designated person below, include their address, city, state, zip, social security number (if known) and relationship to you in the space provided. You must also designate a percentage of your remaining account (if any) to be distributed to that individual.

Note: All percentages must add up to 100%.

Primary Beneficiary(ies)

Name: _____ % _____ Address _____
 _____ City: _____ State: _____ Zip: _____
 SSN: _____ Relationship: _____

Name: _____ % _____ Address _____
 _____ City: _____ State: _____ Zip: _____
 SSN: _____ Relationship: _____

Name: _____ % _____ Address _____
 _____ City: _____ State: _____ Zip: _____
 SSN: _____ Relationship: _____

If all individuals listed as Primary Beneficiaries precede you in death or cannot be located after a reasonable search by the Custodian, all non-allocated funds (if any) in your account will be distributed your Contingent Beneficiary(ies) designated below. In the event that no beneficiary can be located, your account balance (if any) will be distributed to your estate.

Contingent Beneficiary(ies)

Name: _____ % _____ Address _____
 _____ City: _____ State: _____ Zip: _____
 SSN: _____ Relationship: _____

Name: _____ % _____ Address _____
 _____ City: _____ State: _____ Zip: _____
 SSN: _____ Relationship: _____

Note: Special rules apply in certain states if a married individual does not select his/her spouse as beneficiary. If you reside in a community or marital property state and designate a person other than your spouse as beneficiary, you must obtain authorization from your spouse. It is the responsibility of the Account Holder to ensure that the individual(s) designated as beneficiary(ies) are legally authorized to act in that fashion.

Electronic Funds Transfer

I hereby authorize my Plan Service Provider (PSP) to facilitate Electronic Funds Transfer (EFT) between my Health Savings Account (HSA) and my Personal Bank Account as indicated below. These EFT transactions will be facilitated by the PSP but will be initiated by the Custodian. EFT transactions will be either a withdrawal from my Personal Bank Account for subsequent deposit into my HSA or will be a withdrawal from my HSA for subsequent deposit into my Personal Bank Account.

Account Type: Checking Account Savings Account

Bank Name: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Bank Routing Number (First 9 numbers on bottom of check): _____
 Bank Account Number (Second set of numbers): _____

Debit Card Payment Method

I hereby request a mySourceCard® Mastercard® debit card as an alternate distribution method from my HSA account. I understand that additional fees may apply. (See Article IV of the Custodial Account Agreement for terms of usage.) Print exactly as you would like it to appear on your card. 21 characters maximum, including spaces.

Name on 1st Card:

Name on 2nd Card:

Custodian

National Advisors Trust of South Dakota, Inc.
P.O. Box 874080, Kansas City, MO 64187-4080
Toll-free: (877) 527-3476 • Fax: (877) 452-7329 • info@natrustco.com

Custodial Account Manager

DataPath Financial Services, Inc.
P.O. Box 55068 • Little Rock, AR 72215
Web: www.myHSAtoday.com • Email: info@myHSAtoday.com

Plan Service Provider

Name: _____
 Address: _____
 Phone: _____ Email: _____
 Web Address: _____

Marketing Representative

Name: _____
 Serial Number (to be completed by the PSP): _____

Official Use Only	Account Number: _____	Date: _____
	Notes: _____	Signature: _____

Completing the Application and Beneficiary Designation Form

Important: Before completing the Application and Beneficiary Designation Form, carefully read the HSA Custodial Account Agreement, HSA Disclosure Statement, HSA Terms and Conditions, and Privacy Protection Notice. When completing the application, all fields marked with an asterisk (*) must be completed.

Step 1 Complete the “Account Holder Information” section. Your Social Security Number and Date of Birth are required for identification purposes. “Mother’s Maiden Name” and “City of Birth” are required for security purposes. If you have listed both a street address and P.O. Box, be sure to check one of the options for “Preferred Mailing Address.”

Step 2 Complete the “Employer Information” section only if you are applying for an HSA through your workplace. If you are self-employed, you may skip this section and move to step three.

Step 3 Complete the “Eligibility Information” section to determine your eligibility for an HSA. If the answer to either question is “no,” you should contact your Plan Service Provider to determine if an HSA is right for you. If the answers to all three questions are “yes,” proceed to step 4.

Step 4 Complete the “HDHP Information” section and then sign and date the application under the “Adoption Agreement” section. “HDHP” stands for high-deductible health plan. The “Carrier Name” is the insurance company. The “Plan Effective Date” is the date you are eligible for coverage under the insurance plan. The “Deductible Amount” is the dollar amount of your deductible.

Step 5 Complete the “Primary Beneficiary” and “Contingent Beneficiary” sections which indicate the person(s) who will inherit your Health Savings Account upon your death (usually your spouse or children). If no one is listed, the account will transfer to your estate.

Step 6 Complete the “Electronic Funds Transfer” section to authorize transfers between your Personal Bank Account and your HSA. Check the box in the “Debit Card Payment Method” section if you wish to receive a debit card as an alternative distribution method. Mail the application to your Plan Service Provider. Your PSP will then forward this form to the Custodial Account Manager to establish your Health Savings Account.

HSA Accounts Held By:

Custodian: National Advisors Trust of South Dakota, Inc.
P.O. Box 874080 | Kansas City, MO 64187-4080
Web: www.NationalAdvisors.com | E-mail: info@natrustco.com
Phone: (877) 527-3476 | Fax: (877) 452-7329
For current rates, go to www.myhsatoday.com/nat