

Beneficial Administration Co., Inc.
 2505 McCabe Way
 Irvine, CA 92614-6243

HEALTH SAVINGS ACCOUNT APPLICATION AND ELIGIBILITY FORM

For Insurance Agents **ONLY**

AIN#

Code In. Org.

Internal Use:

EGN#

Instructions: All fields must be completed. Return this Application with a check to: **Beneficial Administration Co., Inc. (BAC)**
 2505 McCabe Way, Irvine, CA 92614-6243
Note: All Trustee Services will be provided by HSA Bank, 211 N. Wisconsin Drive, Howards Grove, WI 53083

Make Check Payable to BAC:
 Set-up Fee \$ 20.00
 Check Order \$ _____
 Initial Contribution \$ _____
 Total Amount Enclosed \$ _____

Personal Information: Please fill in all boxes (MM DD YYYY) (IE: 01 01 2004)

Social Security # _____ **Birth Date** _____

First Name _____ **MI** _____ **Last Name** _____

Street Address _____
Required

PO Box _____ **City** _____

State _____ **Zip** _____ **Preferred Mailing Method** Street Address PO Box

County _____

Home # _____ **Bus. #** _____

Form of Identification Driver's License State ID Passport **ID#:** _____

E-mail (optional) _____

Note: 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 to you: When you open an account we will ask for your name, street 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.

Type of initial deposit – Please check one

Regular – Year of Contribution (required)

Rollover (Please attach rollover form)

Trustee to Trustee Transfer (Please attach transfer form)

Initial Contribution Source and Amount

Account Holder and/or Family Member Deposit

Total "Above the Line" Deductions Amt. (\$) .

Employer and/or Section 125 Plan Deposit

Total Pre-Tax Deductions Amt. (\$) .

Employer Information (For help, see your Employer Rep. or Agent)

Employer Name _____ Employer Contact Name _____

Mailing Address _____ Type of Business _____

City _____ State _____ Zip _____

Eligibility Requirements: REGULAR HSA

Yes No **Account holder certification** – I certify that: (1) I am covered by a Qualified High Deductible Health Plan (QHDHP), (2) I certify that I am not covered by a health plan, other than a QHDHP, which provides any of the same benefits as the QHDHP, (3) I am not entitled to benefits under Medicare, and (4) I may not be claimed as a dependent on another person's tax return.

If you answered NO to the above, you are not eligible to establish a qualified HSA. Upon completion of the eligibility requirements, you may complete the signature section on page two.

