Health Savings Account (HSA) Enrollment Form

All Information Required - Designate Contribution and Beneficiary - Print Clearly - Sign & Date

1. Account Holder - Employee

▶ Mr. ❑ Ms. ❑

Date of Birth | Social Security Number

Home Street Address | Apartment Number

City | State | Zip code

( ) | ( )

Home | Daytime | Email Address

2. Health Plan Information

You must first be enrolled in an HSA compatible High Deductible Health Plan (HDHP) through your Employer. Contact your HR Director for additional information.

Name of Insurance Carrier | Health Plan Type: HMO/PPO/POS | Effective Date of Plan Coverage

3. Employer Information

Name of

4. HSA Contributions - Election To Participate

The payment of insurance premiums charged to me by my employer, as applicable, will be paid pretax via my paycheck. My tax savings will be included in each paycheck - Enrollment Form Not Required. I also authorize pretax deductions from my salary for contributions to my HSA. I understand the amount elected will be deducted evenly each pay period throughout the plan year. I am also aware that I have 90 days (referred to as the "grace period") from the end of the plan year to submit claims for expenses incurred during this plan year which may require an extension to file my individual tax return (Form 1040).

HSA Account Holder warrants: (1) they are covered under a high deductible health plan (HDHP); (2) is not also covered by any other health plan that is not an HDHP; (3) is not enrolled in Medicare; and (4) is not a dependent on another person's tax return.

If individuals listed below are covered by another health plan (except coverage for accident, disability, dental, vision, or long-term care insurance), they are not eligible for "tax-free" reimbursement of health care expenses from your HSA and would create taxable income, plus a 10% penalty to HSA, paid annually to the IRS. Further, the same income tax and

Calendar Year: _____ HSA Calendar Year Contribution: [Contact HR Dept. for maximum] $ _____

5. Other Individuals Covered By Your HDHP

Name	Date of Birth	Relationship	Social Security #

Use extra form for additional individuals

Routing: Original to Employer • Copies for TAI and Account Holder

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Health Savings Account (HSA) Beneficiary Form (Set-up)

Beneficiary Designation - Complete All Sections

6. Account Holder - Employee

▶ Mr. ❑ Ms. ❑

First, MI, Last Name | Social Security Number

7. Please check "one" of the following: Note: Beneficiary always modifiable by filing new form

❑ **Initial Beneficiary Designation:** I designate the individual(s) or entity below as my primary and/or contingent beneficiary(ies) of this HSA.

❑ **Replace Beneficiary(ies):** I designate the individual(s) or entity below as my primary and/or contingent beneficiary(ies) of the account named above and hereby revoke all prior beneficiary(ies) designations, if any, made by me.

❑ **Add Beneficiary(ies):** I designate the individual(s) or entity below as my primary and/or contingent beneficiary(ies) of the above account. This list supplements, but does not replace, the beneficiary(ies) previously designated by me on the date specified. (When adding beneficiaries, if the share % of previously designated

Beneficiary(ies): The individual(s) or entity listed below shall be my primary and/or contingent beneficiary(ies). If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary beneficiary. If more than one primary beneficiary is designated and no distribution percentages are indicated, the beneficiaries will be deemed to own equal share percentages in the account. Multiple contingent beneficiaries with no share percentage indicated will also be deemed to share equally. If primary or contingent beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining beneficiary(ies) shall be increased on a pro-rated basis. If no primary beneficiary(ies) survives me, the contingent beneficiary(ies) shall acquire the designated share of my account.

Name and Address	Date of Birth	Relationship	Social Security #	Primary/Contingent	%

Use extra form for additional beneficiaries

8. Spousal Provisions (Check one):

❑ **I am not married:** If I become married at a future date, I must complete a new Designation of Beneficiary form.

❑ **I am married:** I understand that if I choose to designate a primary beneficiary other than my spouse, my spouse must approve the designation by signing below.

I am the spouse of the above-named Account Holder. I acknowledge that I have received full disclosure of my spouse's HSA. Due to the important tax consequences of waiving any interest in this account, I have been advised to see a tax professional. Neither Trust Administrators or the custodian bank provided tax advice to me. I hereby assign to the Account Holder any interest I have in this account and consent to the beneficiary designation(s) indicated above. I assume full responsibility for any adverse consequences that may result.

Signature of Spouse **Date**

Signature of Witness **Date**

9. Account Holder Authorization

▶

Signature of Account Holder **Date**

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DIRECT DEPOSIT AUTHORIZATION FORM

This form not required for reimbursement through Employer's payroll systen

All Information Required - Print Clearly - Sign & Date Where Indicate

Instructions: Use this Form to commence, change or cancel your direct deposit with TAI. Allow up to th weeks from the date TAI receives your Form to activate your account because of processing by the Fed Reserve. Reimbursement will occur only upon submission of a claim form. You must sign, date and include with this Form a "voided" check - no deposit slips Write "Void" across the middle of the check (make sure the account numbers are legible). For security purposes, TAI may deposit as little as 1 cent to test your dir deposit account.

If you have previously filed a Direct Deposit Form, you do not have to complete this Form.

Employee Name_____Social Security #_____-_____-_____

Home Address (Street)_____

City _____ State_____Zip Code_____

Daytime Phone_(_____)_____

E-Mail Address _____

Check boxes as applicable:

Start Direct Deposit: [ ] Change Account: [ ] Cancel Account [ ]

Indicate Type of Account

Checking Account: [ ] Savings Account [ ]

▶ **Fax this Form with your voided check to 510-451-8611 and TAI will obtain the U.S. Federal Reserve's routing and account numbers on your behalf. Remember, no deposit slips.**

▶ Employee Signature _____ Date _____