



## HEALTH SAVINGS ACCOUNT APPLICATION

### ACCOUNT HOLDER REQUIRED INFORMATION

Account Holder Name (First) \_\_\_\_\_ (M) \_\_\_\_\_ (Last) \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_  
 Home Phone Number \_\_\_\_\_ E-mail \_\_\_\_\_  
 Work Phone Number \_\_\_\_\_ Employer \_\_\_\_\_  
 Driver's License # (Copy must be included with application) \_\_\_\_\_  
 Issue date \_\_\_\_\_ Exp Date \_\_\_\_\_ State Issued by \_\_\_\_\_  
 Desired Password (For in-bank inquiries not website access) \_\_\_\_\_

### HEALTH SAVINGS ACCOUNT COVERAGE

TYPE OF ACCOUNT. See [www.bankwps.com](http://www.bankwps.com) for current interest rates

- |                                    |  |
|------------------------------------|--|
| <input type="checkbox"/> Self-only | <input type="checkbox"/> Interest checking account with debt card access |
| <input type="checkbox"/> Family    | <input type="checkbox"/> 6 month Certificate of Deposit                  |
|                                    | <input type="checkbox"/> 12 month Certificate of Deposit                 |

### BENEFICIARY INFORMATION

#### Primary Beneficiary

_____% Name _____	SS# _____	D/O/B _____	Relationship _____
_____% Name _____	SS# _____	D/O/B _____	Relationship _____
_____% Name _____	SS# _____	D/O/B _____	Relationship _____

(Must total 100%)

#### Secondary Beneficiary

_____% Name _____	SS# _____	D/O/B _____	Relationship _____
_____% Name _____	SS# _____	D/O/B _____	Relationship _____
_____% Name _____	SS# _____	D/O/B _____	Relationship _____

(Must total 100%)

Attach separate paper for additional names.

### CONTRIBUTION TYPE

Amount \$ \_\_\_\_\_ Tax Year \_\_\_\_\_

- |  |  |
|--|--|
| <input type="checkbox"/> Regular               | <input type="checkbox"/> Catch-up (age 55 or older and not enrolled in Medicare)                             |
| <input type="checkbox"/> Rollover from HSA     | <input type="checkbox"/> Rollover from an Archer Medical Savings Account                                     |
| <input type="checkbox"/> Transfer from HAS     | <input type="checkbox"/> Transfer from an Archer Medical Savings Account                                     |
| <input type="checkbox"/> Contribution from IRA | <input type="checkbox"/> Rollover from Health Reimbursement Arrangement/<br>Health Flexible Spending Account |

## ACCOUNT INFORMATION

- Minimum balance to waive monthly maintenance fee for HSA checking is \$500
- Fee if balance is not maintained is \$5/month
- 3 withdrawals per month allowed (either by debit card or check). \$1 fee for each additional withdrawal
- No set up fee or charge for debit card. Checks may be ordered at an additional cost.
- Monthly statements are available electronically.
- Minimum deposit for HSA Certificates of Deposit is \$1000.
- Current interest rates for all HSA products are available on [www.bankwps.com](http://www.bankwps.com).
- HSA custodial agreement, signature card, fee schedule and other disclosures will be mailed within 10 days of receipt of application. Upon return of signed HSA custodial agreement, signature card and deposit, the account will be opened.
- Copy this application and retain for your personal records.
- Mail completed application and copy of driver's license to: WPS Bank  
5900 Gisholt Dr.  
Madison, WI 53713

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## SIGNATURE AND ACKNOWLEDGEMENT

I assume sole responsibility for all consequences relating to my actions concerning the HSA including: determining that I am eligible for a HSA each year I make a contribution and ensuring all contributions are within the limits set forth in the tax laws. I have not received any tax or legal advice from the custodian (Bank) and I will seek the advice of my own tax or legal professional to ensure my compliance with related laws. I release and hold the HSA custodian harmless against any claims, losses or tax consequences arising from my actions. I understand that I may revoke this HSA on or before seven (7) days after the date it is opened.

I understand that information obtained for this application is being requested to comply with the U.S. Patriot Act. I authorize the Bank to perform a Credit Bureau inquiry or access consumer credit reports to verify the information is true and accurate.

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Signature of HSA owner

Date

5900 GISHOLT DR., MADISON, WI 53713 (P) 608-224-5500 (F) 608-224-5555

