HSA Application and Salary Reduction Agreement

This Salary Reduction Agreement (SRA) authorizes your employer to reduce your salary by the indicated amount shown below for the exclusive purpose of facilitating a contribution to your Health Savings Account. Do not send contributions with this form. By completing this agreement, you are indicating that as of the effective date of your contribution election, you are an "Eligible Individual" as defined in the adoption agreement and authorize your employer to facilitate your monthly contributions to your HSA on your behalf.

Please fill out the form below and return to your HR office.

Are you a current HSA account holder?

☐ Yes Fill out only your Name in Section 1 and proceed to Sections 2 through 5.
☐ No Complete ALL information and sign the form. Look in the mail for your HSA Welcome Letter, which includes additional HSA services.

Section 1: Account Holder Information (Please Print)

Name (First, MI, Last) _____

Preferred Mailing Address ☐ Home Address ☐ Mailing Address (if different)

Home Address _____ Mailing Address _____

City _____ City _____

State _____ Zip _____ State _____ Zip _____

Email Address _____

Preferred Phone Number ☐ Home ☐ Work Best Time to Call _____ ☐ AM ☐ PM

Home Phone (___) _____ Work Phone (___) _____

Date of Birth _____ Social Security Number _____

Driver's License Number _____ Mother's Maiden Name (Security) _____

Employer _____

Section 2: Primary Beneficiary

Name (First, MI, Last) _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ 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 to your Contingent Beneficiary (to add/edit/change Contingent Beneficiary(ies), log in to your account). In the event that no beneficiary can be located, your account balance (if any) will be distributed to your estate.

Section 3: HDHP Information and HSA Contribution Election

HDHP Coverage Effective Date _____ Check one ☐ Single Coverage ☐ Family Coverage

I elect a monthly contribution of $ _____ (amount) to my HSA effective _____ (date).

Section 4: Debit Card

☐ I hereby request a debit card as an alternate distribution method from my HSA account. (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. If more than two cards are needed, attach a separate sheet.

Name on 1st Card ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Name on 2nd Card ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Section 5: Adoption Agreement/Employee Signature

As of the effective date of my HSA Contribution Election, I certify that I am an "Eligible Individual" as defined by the Code and do hereby elect a Health Savings Account in accordance with Section 223 and Section 125 of the Internal Revenue Code. I understand this request will not be processed until all paperwork is completed, accepted and approved by my employer. I further understand that I am responsible for all contributions made to my HSA and that my benefits administrator is facilitating but not initiating the contribution. If the account is closed at any time, there will be a $25 closing fee.

This application is for the establishment of my individually owned Health Savings Account at the custodian displayed below. 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 bottom 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. I am currently, or will be upon the date of my first contribution, an Eligible Individual as described in the Custodial Account Agreement. 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. I am currently, or will be upon the date of my contribution, covered by a High Deductible Health Plan (HDHP) that meets the qualifications detailed in the Custodial Account Agreement.

_____ _____

Signature of Account Holder Date

Custodian
National Advisors Trust Company, FSB
10811 Lowell Avenue, Suite 100
Overland Park, KS

Plan Service Provider
DataPath Administrative Services, Inc.
Serial No. 666576474227

PO Box 55068 | Little Rock, AR 72215
501-687-6954 | Toll-Free 877-685-0655 | Toll-Free Fax 888-472-6777
www.datapathadmin.com | benefits@datapathadmin.com