# HSA ADOPTION AGREEMENT

I wish to establish a Health Savings Account (HSA) with Gateway Bank, F.S.B. as the custodian and Benefit Administrators as the Plan Service Provider. I would also like to direct all of my contributions into Gateway Bank's HSA custodial account. I have established a Qualified High Deductible Health Insurance Policy as required for the HSA.

## 1. TELL US ABOUT YOURSELF

**Name** **Date of Birth** **Social Security#**

**Street Address** **City** **State** **Zip**

( ) ( )
**Home Phone** **Business Phone** **Email Address**

**[ ] Driver's License# [ ] State ID or [ ] Passport#** *** * * Attach copy of identification (if missing, application will be returned) * * ***

## 2. TELL US ABOUT YOUR BENEFICIARIES

| Beneficiary | Relationship | S.S.# | Birthdate | Gender |
|---|---|---|---|---|
| | | | | |
| | | | | |

In the event of the Account Holder's death, the balance in the account shall be paid to the Primary Beneficiary (ies) who survives the Account Holder in equal shares (or in the specified shares, if indicated). If none of the Primary Beneficiary (ies) survives the Account Holder, the balance in the account shall be paid to the contingent Beneficiary (ies) who survives the Account Holder in equal shares (or in the specified mode, if indicated). The Account Holder has the right to change this designation of beneficiary (ies) at any time by writing to the Custodian. If the Account Holder's beneficiary (ies) does not survive the Account Holder, or if the Custodian cannot locate the beneficiary (ies) after reasonable search, the balance in this account will be paid to the Account Holder's estate.

## 3. ELIGIBILITY

☐ I certify that: (1) I am covered by a Qualified High Deductible Health Plan (QHDHP), and (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.

☐ I am eligible for an HSA as an **employee** of an Employer who is offering them: Name of Employer: ______________________

Contact Name______________________________________________________ Phone#(_______)_______________________________________________

## 4. HSA QUALIFIED HEALTH POLICY

Name of your current insurance company______________________________________________Policy Number___________________________________

[ ] Individual or [ ] Family Deductible Amount: $______________________________ Effective Coverage Date: _________/_______/________

## 5. HSA PLANS, DEDUCTIBLES & DEPOSIT OPTIONS

High Deductible Health Plan (HDHP) generally means, as defined in IRC Section 223(c)(2), a health plan, which satisfies the following requirements regarding deductibles and expenses for Tax year 2006: (a) For single coverage, the deductible must not be less than $1,050 with annual out-of-pocket expenses not exceeding $5,450, or (b) for family coverage, the deductible must not be less than $2,100 with annual out-of-pocket expenses not exceeding $10,500. The maximum amount of contribution in any one year that can be made is the lesser of: the annual deductible or $2,700 for single coverage, and the annual deductible or $5,250 for family coverage. The maximum HSA deposit amount is based on the insurance deductible you choose. The above maximums represent the legal monthly limit of 1/12th of the single deductible and 1/12th of the family deductible. It is recommended that you deposit the maximum amount allowed by law, however you may choose a lesser amount.

## 6. HOW TO FUND THIS ACCOUNT

There are two ways of funding your HSA account. You can elect to mail a check, or authorize Benefit Administrators to electronically transfer (ACH) funds from your personal account and transfer them into your health savings account. Available ACH dates are on the 1st or 15th day of each month. You may fund your Health Savings Account monthly or all at once. The frequency at which multiple HSA contributions are made can vary in amount and regularity, but not exceed your maximum amount. The maximum amount, however, must be made no later than the last day of the current tax season.

☐ **ACH** I hereby authorize these monthly payment amounts: **HSA Deposit $_________, + HSA Monthly Fee $_________, Totaling $__________** to be paid on or about the 1st ___ day of each month or the 15th ___ day of the month. ***Please attach a voided check for the account that contributions will be made from.***

☐ I decline the ACH option, and would rather contribute to my HSA by check. I understand that I can send one lump sum, or multiple contributions.

☐ I will be submitting my contributions through my employer via payroll deduction.

## 7. HSA MANAGEMENT

As custodian, Gateway Bank, F.S.B. is responsible for the money in your Health Savings Account and Benefit Administrators as your agent is the Plan Service Provider responsible for administrative and accounting details of your HSA. ***HSA Earnings*** are based upon the rates, factors and methodologies indicated on the Truth In Savings Disclosure form accompanying your HSA. ***HSA Distributions*** are made simply by using the HSA stored value payment card or by completing the information on the ***HSA Distribution Order*** form provided to you by Benefit Administrators. You do not have to attach bills or receipts. Keep your receipts with your important tax records. Mail the completed form to Benefit Administrators, 1009 Oak Hill Road, Third Floor, Lafayette, CA 94549. Your HSA distribution will automatically be deposited back into your Personal Bank Account or issued by check without further notification. HSA Deposits are automatically made for you on a monthly basis by electronic transfer from your personal bank account into your HSA through the Bank Automated Clearing House System or can be made by sending a check. ***For Employees of Employers*** are collected monthly from the employer. HSA Deposits made by you are payroll deducted by your Employer on a pre-tax basis. HSA Deposits made by your employer on your behalf are made outside of payroll as an employer business expense. Note: Either or both, Employees OR Employers, can make deposits to your HSA during the same plan year. ***HSA Rollovers/Transfers*** require the ***HSA Rollover/Transfer*** form to be completed and then forwarded to the Receiving Custodian for their acceptance authorization. Then forward the form to Benefit Administrators. Your HSA rollover / transfer order will be executed according to the instructions. ***HSA Changes*** may be required whenever you change medical plans, deductibles, beneficiary designations or the monthly deposit amount. You hereby agree to contact Benefit Administrators at (888) 672-1997 during normal business hours of 8:00am – 5:00pm PST to make any necessary changes to your HSA. ***HSA Fees*** include a ***$3.00 Monthly Maintenance Fee*** which will be automatically deducted from your personal bank account each month, or you will be sent an invoice if not prepaid. The ***$25.00 One-Time Set-Up Fee*** paid at application time. There will be a ***$5.00 Change Fee*** charged to your HSA for any changes requested and a **$25.00 Account Termination Fee**. ***Bank Service Fees*** if any, covering such items as NSF checks, Stop Orders, etc. will be deducted from your HSA as they occur. ***HSA Reports*** include Quarterly Statements itemizing deposit and disbursement.

Under penalties of perjury, I certify that the above information (including my social security number) is correct. I hereby agree to participate in the Medical Savings Account offered by the Custodian. I acknowledge receipt of a copy of HSA Custodial Account Agreement, the document under which this Medical Savings Account is established, a copy of this Adoption Agreement, a copy of the HSA Disclosure Statement, and affirm that I have been given notice as required by the Fair Credit Reporting Act. I also, understand the effective date of my insurance will be the effective date stated in my qualifying policy and my HSA effective date will be the same assuming my policy starts on the first of the month. If the effective date of my qualifying policy starts after the first day of the month then my HSA effective date will be the first day of the following month.

I assume complete responsibility for:

1. Determining that I am eligible for an HSA each year I make a contribution. 2. Ensuring that all contributions I make are within the limits set forth by the tax laws. 3. The tax consequences of any contribution (including rollover contributions) and distributions.

**HSA Account Holder Signature**_______________________________________**Date**____________________

Are you rolling over from an MSA?

YES_____ NO______

If yes, from where?:

Name

______________________________________________________________________

***PLEASE RETURN THIS ADOPTION AGREEMENT AND ALL OTHER NECESSARY ITEMS RELATING TO YOUR HSA TO***

**Benefit Administrators ♦ 1009 Oak Hill Rd. 3rd Floor ♦ Lafayette, CA 94549**

**Phone (888) 672-1997, ext. 8555 ♦ Fax (925) 299-8010**