

HSA Application

Complete electronically (Optional)



Send applications here ▶ PO Box 7338 St. Cloud, MN 56302 888.343.4422 HSAResources.com

1 Personal Information.

Name _____ Soc. Sec. # _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip _____

Mailing Address if different from above _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Employer _____ Agent/Broker _____

E-mail _____ Driver's License _____ State Issued _____

Mother's Maiden Name _____ Birth Place _____ Type of Health Insurance Self-Only Family

Internet Banking User ID# (Optional) _____ 6-10 Characters Case Sensitive Debit Card (optional) Yes, send me a free debit card

2 Contribution Information. (Do Not Complete for Employer Plans: Skip this section if your HSA contributions are coming directly from your employer.)

A. Type Regular Rollover Transfer (complete Transfer Form) (Set Up Fee deducted from HSA if not included)

B. Tax Year: Current Year or Prior Year

D. Automated Contributions: (If you want to set up monthly deposits to your HSA from your checking account, complete the following.) You must attach a voided check from the account you wish to withdraw from.

Amount \$ _____ Day of Month 15th or 30th

Make Check Payable to HSA Resources

Initial Contribution (\$35 min): \$ _____
Set Up Fee: \$ _____
Checks (\$12 for 50): \$ _____
Total: \$ _____

Annual Fee: \$25. See www.HSAResources.com

3 Signatures. I have received, either in print or electronically (available at www.HSAResources.com) read and agree to the terms in the Custodial Agreement and Disclosure Statement and I agree that those terms and conditions apply to this HSA and that I am bound by those terms and conditions. If applicable, I hereby designate the beneficiaries for this HSA as those named on the second page of this Application in the HSA Designation of Beneficiary section. If applicable, I hereby authorize the person named on the second page of this Application in the HSA Authorized Signer section as an authorized signer for this HSA. I understand that I am solely responsible to determine my eligibility to make this HSA contribution and to determine the tax deductibility of the contribution; including an understanding that I must be covered under a "High Deductible Health Plan" for annual contribution eligibility. I agree that I will consult with my tax or legal advisor if I need advice. I acknowledge that HSA Resources, LLC and Stearns Bank, N.A. cannot and do not provide me with tax or legal advice. I am solely responsible for determining the tax consequences of all distributions. I acknowledge that the information provided is subject to Stearns' Bank's Privacy Policy but will be shared with HSA Resources, LLC, and limited information may be shared with your insurance agent and your employer. If applicable, I hereby apply for a Point of Sale (POS) Card to be used in conjunction with this account. I agree that use of the POS Card will be subject to the terms and conditions obtained in the Deposit Account Agreement and Disclosure and Regulation E Disclosure that will be provided to me. I authorize Stearns Bank to retain this application and any other credit information, even if this POS Card is not granted. I agree not to use the POS Card Service in any illegal manner.

T.I.N./Backup Withholding. (Cross out item (3) if you are subject to backup withholding) Under penalties of perjury, I certify (1) that the number shown is my correct taxpayer ID number or social security number, (2) that I am a U.S. person (including U.S. resident alien), (3) and that I am not subject to backup withholding because (a) I am exempt from backup withholding or (b) because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends or (c) because the IRS has notified me that I am no longer subject to backup withholding. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Minnesota Legal Requirement. (Cross out item (1) or (2) if untrue) (1) I have not had a transaction account closed at this or another financial intermediary within 12 months before mailing this Application; (2) I have not been convicted of a criminal offense because of the use of a check or other similar items within 24 months of making this Application.

HSA Owner Signature Date

Check here if you completed the second page of this application.
Page 1 (this page) - Required information to open an HSA
Page 2 (next page) - Optional beneficiary and authorized signer information can be completed at any time.

Internal Use: Broker/Agent user ID _____

