HSA *TODAY*
PSP – EMPLOYER – EMPLOYEE DOCUMENTS

DATAPATH INC.

JUNE 2010

HSA *Today* Save today for a healthy future

HSA *Today* PSP Data Gathering Form

General Information

Entity Name: ____

(Enter name exactly as it appears on tax returns and is to appear in the documents.)

Federal Tax ID No: ______________________ Date Incorporated/Organized: ______________

Mailing Address: ____

City: ______________________ State: __________ Zip: __________

Street Address: ______________________________ Zip: __________

Organization Type:

- ❑ Corporation.
- ❑ Sub-chapter "S" Corporation
- ❑ Professional Corporation
- ❑ Professional Association
- ❑ Partnership
- ❑ Sole Proprietorship
- ❑ Government Agency
- ❑ LLC Limited Liability Company
- ❑ Other ______________________________

Entity Information

Entity Logo (Preferably JPEG) : Email a jpeg file of the logo you want on the main page to support@myhsatoday.com

Entity Colors: Primary ______________________ Secondary: ______________________

Entity Primary Email Address: ____

Line of Service: ❑ HSA *Today*

Administrator Information

Name:	First	MI	Last
Job Title\Position:			
SSN:		Date of Birth:	
Email Address:			
Work Phone:		Extension:	
Work Fax:			
	For additional users please complete the myRSC TPA User Access Request\Removal Form.		

myHSAToday.com

Do you want to be listed as an HSA Plan Service Provider on the Website, www.myHSAtoday.com? ❑ YES ❑ NO

If yes, which states do you want to be listed: ____

Authorized Signature

Signature: ______________________________ Date: ______________

*** Please Fax this Form to the Attention of:**
DataPath Financial Services
Fax #: 501.687.1409

HSA*Today* PSP Data Gathering Form Instructions

(To be completed by the Third Party Administrator (Plan Service Provider)

This form must be completed if the PSP (Plan Service Provider). This form will provide DFS with the necessary information to begin setup process for the Company.

General Information

1. Entity Name (required)
2. Federal Tax Id Number (required)
3. Date Incorporated (optional)
4. Mailing Address (optional)
5. Street Address (required)
6. Organization Type (required)

Entity Information

1. Entity Logo (optional)
2. Entity Colors (optional)
3. Entity Email Address (required)
4. Line of Service

Administrator Information – We will use this information also to assign access for the PSP. Any additional users that need PSP access will need to complete the myRSC TPA User Access Request\Removal Form.

1. Name (required)
2. Job Title (optional)
3. SSN (required)
4. Date of Birth (required)
5. Email Address (required)
6. Work Phone (required)
7. Work Fax (optional)

MyHSAtoday.com

1. Complete this section if you would like to be listed as a Plan Service Provider on the myhsatoday.com website.

Authorized Signature

Sign, date and fax to DataPath Financial Services 501.687.1409.

*in*Touch™/myRSC.com™ User Access Request/Removal Form

Please fill out all required fields below to authorize the addition or removal of TPA user access to in*Touch and/or myRSC*.com.

User Information

** Indicates a Required Field*

*** User's Name:** ____

(First) (Middle) (Last)

*** Job Title/Position:** ____

*** SSN:** ____

Note: SSN only required for TPA access to myRSC.com. Not required for inTouch only Access.

*** Work Phone:** ____________________ **Ext:** _____ *** Email Address:** ____________________

*in*Touch Access Requirements

Please check all that apply.

- ☐ **Grant User Access to inTouch**
  - ☐ **Grant User Access to Download Software Updates**
  - ☐ **User Receives DataPath Voice Emails**
  - ☐ **User Receives DataPath Alert and Update Emails**
  - ☐ **User Receives DataPath Marketing Emails**
- ☐ **Remove User Access from inTouch**
- ☐ **Reset User Login to inTouch**

*my*RSC Access Requirements

Please check all that apply.

- ☐ **Grant TPA Access to myRSC.com**
- ☐ **Reset Previous myRSC**
- ☐ **Remove User Access from myRSC**

All requests must be approved and signed by the user's supervisor or an authorized officer before any access will be assigned.

Authorizing Individual Information

** Indicates a Required Field*

*** Company Name:** ____

*** Authorized Individual Requesting the Change:** ____

(First Name) (Middle Initial) (Last Name)

*** Job Title/Position:** ____

*** Work Phone:** ____________________ **Ext:** _____ **Email Address:** ____________________

Authorized Signature

*** Signature:** ______________________________ *** Date:** ________________

You may email the completed and signed form to support@dpath.com, or fax/mail the form using the information below.

*** Please Fax this Form to the Attention of:**
DataPath Customer Service
Fax #: 501.296.9940

OR

Mail Form to:
DataPath, Inc.
1601 Westpark Drive, Suite 9
Little Rock, AR 72204

HSA *TODAY*™ EMPLOYER INFORMATION & FUNDING FORM

General Information

Entity Name: ____

(Enter name exactly as it appears on tax returns and is to appear in the documents.)

Federal Tax ID No: ____________________ Date Incorporated/Organized: __________

Mailing Address:

City: ____________________ State: __________ Zip: __________

Street Address: ______________________________ Zip: __________

Organization Type:
- ❑ Corporation.
- ❑ Professional Corporation
- ❑ Partnership
- ❑ Government Agency
- ❑ Other ______________________________
- ❑ Sub-chapter "S" Corporation
- ❑ Professional Association
- ❑ Sole Proprietorship
- ❑ LLC Limited Liability Company

EMPLOYER PRIMARY CONTACT

Name:			
Title:			
Email:		Voice:	Fax:

HSA FUNDING METHOD [PLEASE CHECK ALL THAT APPLY AND COMPLETE]

Please choose a HSA Funding Method:

❑ Fund by Employer or PSP check made payable to HSAToday

❑ Fund by EFT draft. DFS will draft funds from the following **Employer** Bank account. Please complete bank section below or attach a voided check: (No Fee for EFT Draft) HSA Transmittal Register **must** be completed for each transfer of funds.

Name of Bank: ______________________________

Name on Account: ______________________________

Bank ABA/Route No.:______________________________

Bank Account No.: ______________________________

❑ Fund by Wire Transfer. Employer or PSP initiates a wire transfer of funds into the HSAToday wire account. Please contact DFS at 888-665-1264 and we will supply the Bank Account Information to complete the wire transfer. Must complete HSA Transmittal register to notify DFS of funds wired to this account. **(Wire Fee of $30.00 – must be included in transfer amount. Wire fee will not be waived)**

❑ Fund by ACH Transfer. Employer or PSP will push funds to the same account given by DFS via an ACH Transfer. (NO FEE)

HSA FUNDING FROM PSP BANK ACCOUNT [PLEASE CHECK ALL THAT APPLY AND COMPLETE]

❑ Funded via PSP Account. No fee for EFT Draft. PSP must complete a transmittal register each time there are funds that must be drafted from an account.

Bank Name: ______________________________

PSP Bank Route#: __________________ PSP Account #______________________

❑ Checking ❑ Savings

Required Signature(s) [PSP SIGNATURE REQUIRED]

Employer Name: __________________ Signature: ______________________ Date: __________

PSP Name: __________________ Signature: ______________________ Date: __________

Employer Information & Funding Form Instructions
(To be completed by the Employer)

This form must be completed by the Employer or PSP (TPA) for each Employer to show how DFS will be receiving the funds for HSA contributions. **This form must be completed only once.**

General Information

1. Entity Name (required)
2. Federal Tax Id Number (required)
3. Date Incorporated (optional)
4. Mailing Address (optional)
5. Street Address (required)
6. Organization Type (required)

Employer Primary Contact – enter information for a person that will be the primary contact for that Employer regarding HSA's

HSA Funding Method – choose one method

1. Employer or PSP check – if DFS receives a check directly from the employer, the employer must submit the contributions to the PSP to enter into the system
2. EFT – funds will be drafted from the Employer or PSP account by DFS. No fee for EFT Draft. Transmittal form must be completed and sent to DFS. If there is no HSA transmittal register completed each time, DFS cannot draft the funds.
3. Wire Transfer – Employer or PSP can wire funds to a specified account. Must complete an HSA transmittal register. **Wire fee of 30.00 must be included with the transfer total. Wire fee will not be waived.**
4. ACH Transfer – fund by ACH transfer. Employer or PSP will push funds to the same account given by DFS via an ACH Transfer. There will not be a fee if the employer or PSP is pushing the funds to DFS account.

HSA Funding From PSP Bank Account – select this option if the funds are to be drafted from the PSP bank account by DFS. There is no fee for this transaction. PSP must complete a transmittal register each time there are funds that must be drafted from an account.

1. Fund via PSP Account
2. Bank Name
3. Bank Routing Number (required)
4. Bank Account Number (required)

Authorized Signature

1. Employer must sign if any funds are to be drafted from the employer account
2. PSP is required to always sign this form. If the employer is going to send monies directly to DFS, PSP need to sign the funding form for verification. Employer will also need to send contribution report to the PSP to enter the correct amount for the contributions.
3. Sign, date and fax to DataPath Financial Services 501.687.1409.

HSA Transmittal Register

Custodian: National Advisors Trust
Fax #: 501-687-1409
Email: support@myhsatoday.com

Company Information

Sending Company Tax ID Number: ______________________________

Sending Company Name: ______________________________

Sending Company Phone: ____________________ ext: ________

Contact Name: ______________________________

Instructions

1. If sending HSA contributions by check, please mail check and this complete transmittal to the following address:
2. If EFT draft, then please note that DFS will be drafting for the total contribution amount listed below under the amount. Please Mail, email or Fax the completed form to the address below:
3. If Sending via Wire Transfer, then please call DFS at **888-665-1264** and we will supply the Bank Account information necessary to complete the wire transfer. There is a$30.00 wire fee that must be included with the total. This fee will not be waived

Mail
Or Fax to:

DataPath Financial Services, Inc.
P.O. Box 55068
Little Rock, AR 72215
Fax: 501-687-1409

Method of Funding

Mail Check: ☐	**Check #:**	____________	**Check Date:**	____/____/____
EFT (bank draft): ☐	(DFS PULL)	No Fee	**EFT Date:**	____/____/____
ACH (bank draft): ☐	(PSP or ER PUSH)	No Fee	**ACH Date:**	____/____/____
Wire Transfer: ☐	(PSP Push)	**$30.00 fee**	**WIRE Date:**	____/____/____

Amount of Transfer

		Participant	Amount
Total Contribution Amount:	$__________	____________________	$ ____________
Plus Wire Transfer Fee:	$30.00 (add to wire)	____________________	$ ____________
Total Amount Transferred:	$__________	____________________	$ ____________
		____________________	$ ____________

(Or provide a contribution Report)

Security Signature

Authorized Signature X: ______________________________ ____/____/____
(An authorized signature must accompany each HSA transfer of money to be valid)

Please Print Name: ______________________________

HSA Employer Transmittal Register Instructions

(To be completed by the Employer or TPA, entity from which we will receive the funds via EFT transfer or wire)

This form must be completed by the PSP (TPA) or the Employer to notify DFS the contribution amount to Draft or that will be sent via check or Wire. It is not required to send a transmittal form with a check.

Company Information

1. Sending Company Tax Id Number (required) – this can be for the employer or the PSP (sending entity)
2. Sending Company Name (required)
3. Sending Company Phone (required)
4. Contact Name

Instructions

1. Employer or PSP check – check from employer can be forwarded to DFS from the TPA or the TPA can deposit into TPA account and write check to DFS.
2. EFT – this method will be drafted from the Employer account by DFS
3. Wire Transfer – Employer or PSP can wire funds to a specified account. Wire fee of 30.00 must be included with the transfer total.

Method of Funding – check one

1. Check - If multiple checks are sent, use one form and put the check number next to the participant
2. EFT (DFS PULL) – DFS will NOT be able to pull any funds unless this form is completed. No fee for this transaction
3. ACH (PSP or ER PUSH) Employer or PSP can send funds via EFT to a specified account. No fee for this transaction.
4. Wire – form must be completed before Wired funds will be applied to the HSA Accounts. 30.00 Fee must be included in the transmittal total

Amount of Transfer

1. Total Contribution amount for EFT or Wire
2. Add 30.00 wire fee (add in total if sending to the wire account)
3. Total Amount Transferred including the wire fee if applicable
4. Participant – list the employer the amount should be applied to
5. Amount – amount to be transferred

Authorized Signature

1. Employer or PSP must sign form, depending on which entity we are to draft the funds.
2. Sign, date and fax to DataPath Financial Services 501.687.1409.

HSA *Today*® Custodial Account Agreement

Introduction

Read this Agreement thoroughly before completing the Application. By signing the Application, you understand and agree to the terms and conditions of this Agreement and have executed an Application in order to establish a Health Savings Account ("HSA") with the Custodian under Section 223, its sub-sections, and applicable rulings and provisions of the Code.

An HSA is an individually owned account maintained at a financial institution where tax-favored contributions can be made on behalf of individuals covered under certain High Deductible Health Plans ("HDHPs") with tax-free distributions allowed for qualified medical expenses. Note: An individual establishing an HSA is not entitled to tax favored treatment unless certain federal requirements are met. These requirements are summarized in this Agreement. Your HSA funds will be maintained by the Custodian and will indicate which portion, if any, of your funds reside in an FDIC insured account. Your HSA funds will earn interest in accordance to your Custodian's published rates.

An HSA is established pursuant to federal tax law, and is neither endorsed by nor sponsored by an employer. Rather, it is an individual account arrangement between the Account Holder and the Custodian. As a result, the HSA is not part of an employer's ERISA benefit plan, even if the employer contributes to it or the employee makes pre-tax contributions to the HSA under an employer's cafeteria plan. This Agreement is mutually acknowledged and agreed upon by the Custodian and the Account Holder (known collectively as the "Parties").

Definitions

Account: Your individual HSA with the Custodian.

Account Balance: The current amount of money maintained within your Account, which is calculated as all cash contributions plus any earnings and adjusting credits, less any losses, applicable fees, distributions, and reconciliation adjustments.

Account Holder: The individual who has executed the Application. The Account Holder is the owner of the HSA. Herein referenced as "you" or "your".

Agreement: This Custodial Account Agreement, HSA Disclosure Statement, HSA Terms and Conditions Statement, and Privacy Protection Notice.

Application: The Application & Beneficiary Designation Form.

Beneficiary: The person or persons named on the Application who would succeed in ownership of the funds upon your death.

Code: The Internal Revenue Code of 1986, as amended, and all rules and regulations adopted thereunder.

Contribution: The money deposited into your HSA by you or on your behalf.

Custodian: The financial institution named on the Application that maintains your Account. Herein referred to as "we", "our" or "us".

Disbursement: Any money withdrawn from your HSA. May also be referred to as a Distribution.

ERISA: The Employee Retirement Income Security Act of 1974, as amended, and all rules and regulations adopted thereunder.

Plan Service Provider ("PSP"): The entity named on the Application that performs various administrative services for you and / or your employer group and is your authorized representative and agent. The PSP is registered with the Custodian and may be, but is not required to be, an insurance agency or licensed third party administrator. You agree to allow us to share information with the PSP (and its agents and sub-contractors) as may be necessary for the PSP to perform services related to your Account.

Article I – Duties and Responsibilities of the Custodian

We will establish an HSA for an individual upon submission of a properly executed Application. Our sole obligations are as set forth herein. We assume no fiduciary status with regard to your HSA.

We will maintain your personal information, including but not limited to, your name, address, phone numbers, and tax identification number as confidential information and will release such information only when necessary for completing transactions, when required to do so by court order or governmental agency, or if you give us written permission.

We will maintain your Account as a separate Account, distinct from all other Accounts, for your exclusive benefit and the benefit of your beneficiaries and we shall be responsible for performing only such services as are described in this Agreement.

We agree to provide you with a statement of activity on a monthly basis. Unless you file with us a written objection to the statement within 20 days after the statement is furnished, we will be relieved and discharged from all liability to you or your beneficiary with respect to all matters set forth in such statement.

We will apply interest to your Account in accordance with the current published rate(s) as may be adjusted from time to time.

We may accept cash contributions on your behalf during your tax year and such contributions will be applied to the tax year in which they were received by us unless otherwise designated by you. The total cash contributions are limited to the maximum statutory amounts (as established under Code Section 223) or as otherwise in this Agreement. Such contributions will be deposited into your Account at the first available opportunity after we have established the validity of the deposit.

We agree to submit reports to the Internal Revenue Service (the "IRS") and to you as prescribed by the IRS.

We encourage you to retain a copy of this Agreement with your personal financial records.

We have the authority to contract the services of qualified entities for the sole purpose of providing administrative services for your Account. This entity will be bound by a separate agreement, executed by that entity and us and will enumerate the duties to be performed.

We will assume all Disbursements from your Account to be a Normal Distribution and not subject to income or excise tax unless notified by you within the applicable tax year. A Normal Distribution is defined as a withdrawal of money from your Account for the exclusive purpose of a qualified medical expense as defined by the Code.

We will not provide any investment advice to you now or in the future even if investment options become available through your Account.

We agree to charge fees as indicated in this Agreement. We reserve the right to change the fees as indicated in this Agreement from time to time and will provide you with notice of the change prior to the effective date of the change.

We are not responsible for inquiring into the nature or amount of any contribution made to your Account by you or on your behalf by another individual or entity. We are not responsible for inquiring into the amount or timing of any distribution from your Account requested by you, or whether such contributions or distributions comply with the Code. All materials provided by us are intended solely to provide a general description of HSAs and how they work, and are designed and distributed with the understanding that they do not constitute or include legal, tax, or other professional advice. We assume no responsibility for tax or other consequences to anyone arising from the establishment or use of an HSA with us. By signing the Application, you acknowledge and agree that nothing in this Agreement is construed to confer fiduciary status upon us. You have the full responsibility for any tax or investment consequences of all contributions to and distributions from the Account.

We may have additional duties or responsibilities as detailed in this Agreement.

Article II – Duties and Responsibilities of the Account Holder

You agree to provide the PSP and us with the necessary information as may be required under this Agreement and the Code.

You agree that it is your responsibility to determine your eligibility to establish and contribute to an HSA. You represent that, for any period in which a contribution is made, you: i) are covered under a high deductible health plan (HDHP); ii) are not covered (as a dependent or otherwise) under any plan that is not an HDHP; iii) are not entitled to Medicare; and iv) cannot be claimed as a tax dependent on anyone else's tax return.

You agree that it is your responsibility to be aware of the nature or amount of any contribution to your Account made by you or on your behalf by another individual or entity. You further agree that it is your responsibility to be aware of any amount or timing of any distribution from your Account requested by you, or whether such contributions or distributions comply with the Code. You have the full responsibility for maintaining records relating to contributions and distributions and receipts for qualified medical expenses and any tax or investment consequences of all contributions to and distributions from the Account.

You are required to keep an accurate record of all contributions, receipts, investments, distributions and all other transactions relating to the Account. You may be required to produce such records in the event of an audit by the IRS.

You agree to pay the fees for services performed under this Agreement.

You agree to indemnify, hold harmless, and to defend the PSP, and us against any and all claims arising from liabilities incurred by reason of any action taken by the PSP or us in good faith pursuant to this Agreement.

You understand that no portion of the Account may be invested in Life Insurance. You also understand that you may not borrow from the Account or pledge any portion of the Account as a security or collateral for a loan.

You may have additional duties or responsibilities as detailed in this Agreement.

Article III – Duties and Responsibilities of the PSP

The sole purpose of the PSP is to facilitate your administration of your Account and to provide administrative assistance or services to you.

The PSP is appointed as an authorized representative and agent for the Account Holder and is acknowledged and recognized as such by the Custodian. The PSP is authorized by the Custodian to perform certain administrative services on your behalf or on the behalf of your employer. We recognize that these services vary from PSP to PSP and that any service provided by a PSP is provided outside the duties and responsibilities of you or us. Any service performed by the PSP on your behalf does not relieve you of the responsibility of compliance with all applicable laws including but not limited to tax consequences of Contributions and Distributions.

The PSP is responsible for all services performed by the PSP and is not acting as our agent or subcontractor. We have no obligation or liability to the PSP in respect to the services provided to you.

Article IV – Disbursement Process

You may withdraw all or any of the balance of your Account at any time. To receive a withdrawal from your Account, you must instruct us, through your PSP, to distribute funds, in writing, at the address indicated on the Disbursement Request Form, by using the web portal ("*my*RSC.com"), or by using other procedures as we may from time to time specify (known collectively as the "Disbursement Process"). We may offer additional methods of

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Distributions such as a Credit or Debit Card at a future time without amending this Agreement.

In the event that a *my*SourceCard® MasterCard® Debit Card (the "Card") is issued to you, it will act as a method of Distribution. By signing, using or accepting the card, you agree that the use of the Card will be governed by the terms and conditions of this Agreement and the Cardholder Agreement supplied with the Card. The Card can not be used at all MasterCard® acceptance locations. The Card may not be used to obtain a cash advance from any merchant, bank, or ATM. The use of the Card is restricted for use by yourself and qualified dependents and may only be used for qualified medical expenses as defined by the Code and acceptance of the Card by a merchant may not make a statement of the qualification of such charge as an eligible medical expense. All amounts charged on your Card will be paid by electronically deducting the corresponding amount from your Account and you authorize such deductions to be made in accordance with this Agreement and may not exceed the available cash on deposit, excluding investment account funds, if any, in your Account at the time of purchase. Your PSP will establish the setup, monthly and other fees, if any, associated with the Card and will also establish if such fees, if any, will be deducted from your account, paid by your employer, or paid by you with non-Account funds.

The availability of funds in your account may be subject to reasonable funds availability rules imposed by us. You may make Distributions from your Account up to the amount of your Account Balance. At no time may you withdraw more funds than are available in your Account.

You are responsible for complying with all laws governing withdrawals, transfers, and taxes.

Article V - Amendments

This Agreement may be amended automatically from time to time without any action on the part of Account Holder, the PSP, or the Custodian to comply with the provisions of the Code and related regulations. Such amendments may be made retroactively to the later of the effective date of this Agreement or the effective date of any future legal requirements.

Other amendments may be made without your consent and will become effective upon execution of such amendments.

Article VI – Beneficiary Designation

You have the authority and responsibility to designate at least one Account Beneficiary who will receive the benefit of the Account upon your death.

You also have the authority to change this designation at any time for any reason by providing us with written notice.

You understand that in the event of your death, your Account Balance, if any, will be distributed to the individual(s) listed as the Beneficiary(ies) on the Application (or subsequent Beneficiary Change Forms) with appropriate percentages of the Account Balance distributed as noted. If no Beneficiary is provided or if we cannot locate the Beneficiary after a reasonable search, the Account Balance, if any, will be paid to your estate.

If the designated Beneficiary is your spouse, that person may continue the Account as if originally established by him or her.

You understand that in some states, your spouse may be required to provide consent if not named as the Beneficiary. It is your responsibility to ensure that the Beneficiary designation made by you complies with applicable laws.

Article VII – Fees

Fees associated with the services performed by the Custodian under this Agreement are contained within the published fee schedule maintained on the Custodian's website indicated on the Application. We reserve the right to change such fees at any time but no such change that results in an increase in fees shall become effective without 30 days prior notice to you. Maintaining the Account after notice has been provided to you will be deemed as your acceptance of the new fees.

In addition to the availability on the website, a copy of the published effective fee schedule may also be obtained by your PSP who is responsible for the establishment of some of the fees such as the Account Setup and Monthly Fee. Other fees such as an NSF Charges and Close Account Fees, will be assessed against your account. All fees assessed directly against your account will be indicated on your fee schedule. A comprehensive fee schedule is available from your PSP. It is your responsibility to ensure that all Account fees are paid in accordance with this Agreement.

Article VIII – Resignation or Removal of the Custodian

We may resign as the custodian hereunder without your consent, by providing notice of such resignation 30 days prior to the effective date of our resignation. In such event, you shall appoint a qualified successor custodian. Upon our receipt of a written appointment of the successor custodian, we shall transfer and pay over to such successor the assets of the Account. If after 30 days from notice of resignation, we have not received written appointment of a successor custodian, we shall pay or otherwise transfer the assets remaining in the Account to you. We have the right to reserve any necessary balance from the transfer that we deem necessary to make payment for any liabilities constituting a charge against the assets of the Account or a charge against us.

You may remove us as your custodian by providing notice to us at least 30 days prior to our removal. In the event of our removal, you shall appoint a qualified successor custodian who shall assume all rights, powers, privileges, liabilities and duties as your custodian. We will assign, transfer and deliver to the successor all funds and appropriate information of the Account. We have the right to reserve any necessary balance from the transfer that we deem necessary to make payment for any liabilities constituting a charge against the assets of the Account or a charge against us.

Article IX - Notice

Except as otherwise permitted by us, all instructions to us under this Agreement must be in writing. In connection with transactions regarding the Account, the PSP will act as your authorized representative and agent, and will receive written notices from you, which the PSP may communicate to us in written form or electronically in accordance with such procedures and practices as established. You will be bound by any instructions provided to us by the PSP. You must notify us in writing of any change in your PSP designation.

Any notice, report, payment, distribution or other material required to be delivered by us to you under this Agreement, shall be deemed delivered and effective (a) three days after the date mailed by us to your last known address of record as provided on the Application or the last notification of an address change received by us or (b) supplied to myRSC.com for electronic distribution when we have previous knowledge that you have access to the site.

Any notice or instructions required to be delivered by you to us under this Agreement shall be deemed delivered when actually received by us and should be sent to the address shown on the Application or such other address as we may make available to you. Notices should be U.S. mail, first class with postage prepaid and properly addressed.

Article X – General Provisions

Anything contained in this Agreement to the contrary notwithstanding, neither you nor your beneficiary shall be entitled to use any portion of the Account as security for a loan, nor shall we or any other person or institution engage in any prohibited transaction, within the meaning of section 4975 of the Code, with respect to the Account.

Except to the extent otherwise required by law, none of the funds held in the Account shall be subject to the claims of any creditor of you or your beneficiary, nor shall you or your beneficiary have any right to anticipate, sell, pledge, option, encumber or assign any of the benefits, payments or proceeds to which you may be entitled under the Agreement.

Any dispute, controversy or claim arising out of or relating to the Agreement shall be submitted for and settled by binding arbitration upon receipt by either you or us of a written notice calling for such. A single arbitrator appointed by the American Arbitration Association shall conduct arbitration under the commercial rules then prevailing of the American Arbitration Association. The decision of the arbitrator shall be final and binding on both parties and may be entered and enforced in any court of competent jurisdiction by either party. The prevailing party in the arbitration proceeding shall be awarded reasonable attorney fees and all other costs and expenses incurred directly in connection with the proceedings, unless the arbitrator for good cause determines otherwise.

If any question arises as to the meaning of any provision of this Agreement, then we shall be authorized to construe or interpret any such provision, and our construction and interpretation shall be binding upon you and your beneficiary.

Throughout this Agreement, the singular form includes the plural where applicable.

Any provision of this Agreement which would disqualify the Account as an HSA for purposes of the Code, shall be disregarded to the extent necessary to make the Account qualify as an HSA under the Code.

The headings and articles of this Agreement are for convenience of reference only, and shall have no substantive effect on provisions of this Agreement.

The provisions of this Agreement shall be construed and interpreted in accordance with the internal laws of the state in which our principal office is located, except to the extent superseded by applicable federal law.

Notwithstanding any other articles which may be added or incorporated into this Agreement, the provisions of Articles I through X hereof and this sentence will be controlling. Any additional articles or provisions that are not consistent with Section 223, sub-sections, applicable rulings and provisions of the Code will be invalid.

This Agreement is part of a series of documents and agreements executed by the Parties relating to the Account, all of which shall be construed consistently to give effect to the intent of the Parties.

By executing the Application, you are bound by the terms and conditions of this Agreement.

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HSA *Today*® Custodial Account Agreement

HSA DISCLOSURE STATEMENT

OVERVIEW – Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, added section 223 to the Code to permit eligible individuals to establish a Health Savings Account for taxable years beginning after December 31, 2003. A Health Savings Account ("HSA") is an individually owned account maintained at a financial institution where tax-favored contributions can be made on behalf of individuals covered under certain High Deductible Health Plans ("HDHPs") with tax-free distributions allowed for qualified medical expenses. An HSA is portable, which means that the Account Holder can use the HSA after termination of employment or retirement.

GENERAL REQUIREMENTS OF AN HSA – Your contributions must be made in the form of cash or as an Electronic Funds Transfer (EFT). Your regular annual contributions for any taxable year may be deposited at any time during that taxable year and up to the due date for the filing of your federal income tax return for that taxable year, no extensions. This generally means April 15th of the following year.

An HSA can be established under a properly designed cafeteria plan under Section 125 of the Code. This allows you to make a salary reduction of the contribution amount to your HSA. This results in a contribution to the HSA that is deducted from your paycheck before taxes are calculated.

The Custodian of your HSA must be a bank, insurance company or any other entity that is already approved to act in such a capacity by the Secretary of the Treasury.

No portion of your HSA funds may be invested in life insurance contracts.

The assets in your HSA may not be commingled with other property except in a common trust fund or common investment fund.

You may not invest HSA assets in collectibles (as described in Section 408(m) of the Code). A collectible is defined as any work of art, rug or antique, metal or gem, stamp or coin, alcoholic beverage, or any other tangible personal property specified by the IRS. The assets of your HSA remain tax-exempt while the funds are in your account.

ELIGIBILITY FOR AN HSA – You are permitted to make a regular contribution to your HSA for any taxable year if you are an "Eligible Individual." An eligible individual means, with respect to any month, any individual who: (1) is covered under a High Deductible Health Plan (HDHP) on the first day of such month; (2) is not also covered by any other health plan that is not an HDHP; (3) is not enrolled in benefits under Medicare; and (4) may not be claimed as a dependent on another person's tax return.

An HDHP is defined as a High Deductible Health Plan with an annual deductible and out-of-pocket limits that are updated annually for Cost of Living adjustments (see your Plan Service Provider for current limits). The deductible is not required to apply to charges relating to "Preventive Care" expenses.

An individual is not disqualified from being an Eligible Individual solely because he or she has any of the coverage listed below in addition to the HDHP. This coverage is classified as Permitted Insurance and includes insurance if substantially all of the coverage provided under such insurance relates to:

- Liabilities incurred under worker's compensation laws;
- Tort liabilities;
- Liabilities relating to ownership or use of property; or
- Insurance for a specified disease or illness (e.g., cancer insurance);
- Insurance paying a fixed amount per day (or other period) of hospitalization; and
- Insurance for Dental, Vision or Long-Term Care.

An individual is not disqualified from establishing and contributing to an HSA solely because he or she is a participant in a Health FSA with a grace period, provided the individual either has a zero balance on the last day of the plan year or the individual transfers the entire balance to the HSA as of the last day of the plan year (subject to the FSA one time rollover rules set forth below).

CONTRIBUTIONS TO AN HSA – The maximum contribution permitted for an Eligible Individual with self-only coverage of an HDHP is the statutory maximum that is updated annually for Cost of Living adjustments (see your Plan Service Provider for current limits). The maximum contribution permitted for an Eligible Individual with family coverage of an HDHP is the statutory maximum that is updated annually for Cost of Living adjustments (see your Plan Service Provider for current limits). The annual contribution limit is the sum of the limits determined separately for each month based on the individual's status and health plan coverage as of the first day of the month. HSA rules are applied without regard to community property laws.

An individual who first becomes an eligible individual anytime on or before the first day of December of any year is treated as though they are an eligible individual for the entire year so long as they continue to be an eligible individual for 12 months beginning with the last month in the year in which the individual became an eligible individual.

If an individual fails to be an eligible individual during that 12 month period, all contributions attributable to months for which the individual was not an eligible individual during the year are included in gross income for the year in which the individual ceases to be an eligible individual (except for failure to maintain eligible individual status due to disability or death) and such amounts are subject to a 10% excise tax.

Contributions must be made in the form of cash or as an EFT. Contributions can be made by you or by other individuals on your behalf. Your HSA contribution limit is reduced by any contributions made by others on your behalf. Contributions made to your HSA in the form of a Rollover, or transfer of asset, from an MSA or HSA must be in accordance with the Code and must be in the form of cash or as an EFT.

An Eligible Individual who is age 55 or older is allowed to make, or to be made on his or her behalf, an additional contribution amount of $800 for the taxable year beginning in 2007. This additional contribution is called a "Catch-Up" Contribution and will increase by $100 each year until it reaches $1,000 for year 2009 and thereafter.

If an Eligible Individual makes an HSA contribution, a deduction is permitted for the taxable year equal to an amount, which is the aggregate amount, paid in cash during such taxable year to an HSA. All HSA contributions must be made for a calendar year no later than the taxpayer's tax filing due date (generally April 15), not including extensions.

If a married couple is covered under separate HDHPs, then each spouse is eligible for his/her own HSA, in which case each spouse could contribute up to the maximum statutory amount for an individual into his/her own HSA. If a married couple is covered under the same high deductible health plan and each spouse makes contributions to a separate HSA account, then the maximum statutory amount for a family may be divided equally between them or they can agree to divide it in another fashion.

Employer contributions to an employee's HSA, within statutory limits under a cafeteria plan, are not included in compensation paid to the employee. Employers deduct the HSA contributions on their tax return and report the amount on the employee's W-2 form as non-taxable income.

EXCESS CONTRIBUTIONS – Generally, excess HSA contributions is any contribution that exceeds the contribution limits, and such excess contributions are subject to a 6% excise tax on the principal amount of the excess each year until the excess is corrected.

For Post-tax and Employer contributions, the 6% excise tax may be avoided if the excess amount plus the earnings attributable to the excess is distributed by your tax filing deadline including extensions for the year during which the excess contribution was made, and you do not take a deduction for such excess amount. If you decide to correct your excess in this manner, the principal amount of the excess returned is not taxable (but excess employer contributions would have been taxable when made). However, the earnings attributable to the excess are taxable to you in the year that the distribution occurred.

If you do not correct your excess contribution in the manner prescribed above by the due date for filing your tax return, then you may withdraw the principal amount of the excess (no earnings need be distributed). The 6% excise tax will, however, apply first to the year in which the excess contribution was made and each subsequent year until it is withdrawn.

ROLLOVER HSAs – A rollover from another HSA/MSA is any amount you receive from one HSA/MSA and rollover into another HSA. You are not required to roll over the entire amount received from the first HSA/MSA. However, any amount you do not roll over will be taxed at ordinary income tax rates for Federal Income Tax purposes and may be subject to an additional excise tax if the distribution does not meet one of the exceptions. The excise tax will be 10% for the amount withdrawn from an HSA/MSA and not subsequently rolled to another HSA within the allotted timeframe. The following special rules also apply to rollovers between HSAs/MSAs:

- The rollover must be completed no later than the 60th day after the day the distribution was received by you.
- You may have only one HSA/MSA to HSA rollover during a 12 consecutive month period measured from the date you received a distribution of an HSA/MSA which was rolled over to another HSA.
- You are not required to receive a complete distribution from your HSA/MSA in order to make a rollover contribution into another HSA, nor are you required to roll over the entire amount you received from the first HSA.
- If you inherit an HSA/MSA due to the death of the account holder, you may not roll this HSA/MSA into your own HSA unless you are the spouse of the decedent.

In addition, an unlimited amount of direct HSA trustee-to-trustee transfers may occur.

ROLLOVER FSAs/HRAs – A one time rollover from a Health FSA or HRA of the lesser of the Health FSA or HRA balance in effect on September 21, 2006 or the balance as of the date of the rollover to an HSA is permitted at any time prior to January 1, 2012. The Qualified HSA Distribution is treated as a rollover contribution for HSA purposes; therefore, it does not decrease the amount that may be contributed to the HSA during the year. The rollover must be made directly by the employer to the HSA custodian/trustee.

The individual must continue to be an eligible individual for the 12 month period begin-

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ning with the month in which the Qualified HSA Distribution is made or the entire Qualified HSA Distribution will be included in gross income and subject to a 10% excise tax (except for the failure to maintain eligible individual status due to disability or death).

The Qualified HSA Distribution is subject to a modified comparability rule. If the employer makes Qualified HSA Distributions available to any employee, the employer must make Qualified HSA Distributions available to all employees covered under the employer's HDHP.

ROLLOVER IRAs – A one time rollover from trustee-to-trustee transfer of IRA funds to an HSA is permitted to the extent the transfer doesn't exceed the maximum annual HSA contribution amount updated annually for Cost of Living adjustments (see your Plan Service Provider for current limits). The IRA transfer is not treated as a rollover contribution. Thus any amounts transferred from the IRA to the HSA during the year reduce the maximum amount that may otherwise be contributed to the HSA during that year.

If an individual electing the one-time transfer does not remain an eligible individual for the 12 months following the month of the contribution, the transferred amount is included in the income and subject to a 10 percent additional tax.

DISTRIBUTIONS – Any amounts distributed from your HSA account for qualified medical expenses are not included in your gross income for the year and are not subject to the 10% excise tax.
Qualified medical expenses include amounts paid with respect to the individual, the individual's spouse, and the individual's dependents, for medical care defined under section 213(d) of the Code if such amounts are not compensated for any insurance or otherwise. Medical Care includes amount paid:

A) for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body;
B) for transportation primarily for and essential to medical care referred to above; or
C) amounts paid for certain lodging while away from home primarily for and essential to medical care, if such medical care is provided by a physician in a licensed hospital and is no significant element of personal pleasure, recreation or vacation in the travel away from home. The term medical care does not include cosmetic surgery.

Generally qualified medical expenses do not include payment of insurance premiums. Exceptions to this rule include coverage under:

A) a health plan during any period of continuation coverage required under Federal law (COBRA);
B) a qualified long term care insurance contract (as defined in section 7702(b) IRC);
C) a health plan during a period in which the individual is receiving unemployment compensation under any Federal or State law; or
D) Medicare premiums, when deducted from Social Security payments.

Any amounts distributed from an HSA account that are not used to pay for qualified medical expenses are included in the gross income of the taxpayer. Also such distribution will be subject to a 10% excise tax. Exceptions to the 10% excise tax include:

- distributions due to the Account Holder becoming disabled (defined under section 72(m)(7) IRC);
- distributions made to the beneficiary(ies) upon the death of the Account Holder;
- distributions made to an Account Holder after such individual becomes eligible for Medicare. (The age specified in section 1811 of the Social Security Act is currently age 65.); or
- distributions from an HSA/MSA that are subsequently rolled over to another HSA within 60 days from the day of receipt of the distributions.

If the Account Holder designated his/her spouse as the designated beneficiary, the surviving spouse shall be treated as the account holder of the HSA after the Account Holder's death. This means that when the Account Holder dies, if the surviving spouse is the designated beneficiary, then the surviving spouse assumes such account automatically.
If a non-spouse beneficiary (other than the estate) is the designated beneficiary, then the HSA ceases to be an HSA on the date of death, and the fair market value of the Account on the date of death is treated as taxable to such non-spouse beneficiary for such taxable year. If the taxpayer's estate is the designated beneficiary, then the fair market value of the assets in the account are includible in the decedent's gross income on the last tax return of the decedent.
Distributions made to a beneficiary shall not be taxable to the extent that the decedent incurred qualified medical expenses prior to death and the beneficiary pays such amounts within one year of the date of death. If the designated beneficiary is the estate and the decedent's gross income for the last taxable year is increased by the amount of the distribution, then the estate taxes are reduced by such amount.

PROHIBITED TRANSACTIONS – If you or your beneficiary(ies) engage in a prohibited transaction (as defined under Section 4975 of the Code) with your HSA, it will lose its tax exemption and you must include the value of your account in your gross income for that taxable year. If you use your HSA for security or pledge any portion of your HSA as collateral for a loan, the amount so pledged will be treated as a distribution and will be included in your gross income for that year.

REPORTING REQUIREMENT – Each year, we will report to the IRS and to you, as required by the Code. A Tax Form 1099-SA and Tax Form 5498-SA will be made available before the regulatory deadline. The form 1099-SA reflects Distributions from your Account and the Form 5498-SA reflects Contributions and the fair market value of your Account.
If you are an HSA account holder, additional reporting using the Form 8889 is required by you, to be sent along with your Tax Form 1040.

TRANSFERS – A direct transfer of all or a portion of your funds is permitted from this HSA to another HSA or vice versa. Transfers do not constitute a distribution since you are never in receipt of the funds. The monies are transferred directly to the new trustee or custodian.
If you should transfer all or a portion of your HSA to your former spouse's HSA under a divorce decree (or under a written instrument incident to divorce) or separation instrument, you will not be deemed to have made a taxable distribution but merely a transfer. The portion so transferred will be treated at the time of the transfer as the HSA of your spouse or former spouse

This disclosure statement is intended to provide only a summary of the rules and regulations that apply to Health Savings Accounts (HSAs). It is intended to be informational and does not constitute tax or legal advice regarding any specific situation. For more information or tax advice, please contact your tax advisor..

HSA TERMS AND CONDITIONS STATEMENT

AGREEMENT – These terms govern the operation of this account unless varied or supplemented in writing. Unless it would be inconsistent to do so, words and phrases used in this document should be construed so that the singular includes the plural and the plural includes the singular. As used in this form, the words "we", "our", or "us" mean the HSA Custodian as indicated on your HSA application, and the words "you" or "your" mean the account holder(s). This account may not be transferred or assigned without our written consent.
Much of our relationship with our deposit customers is regulated by state and federal law, especially the law relating to negotiable instruments, the law regulating the methods of transferring property upon death and the rights of surviving spouses and dependents, the law pertaining to estate and other succession taxes, the law regarding electronic funds transfer, and the law regarding the availability of deposited funds. This body of law is too large and complex to be reproduced here.
The purpose of this form is to:

1. Summarize the rules applicable to the more common transactions;
2. Establish rules to govern transactions or circumstances, which the law does not regulate; and
3. Establish rules for certain events or transactions which the law already regulates but permits variation by agreement

We may permit some variations from this standard agreement, but any such variations must be agreed to in writing.

LIABILITY – You agree to the terms of this Account and the schedule of charges that may be imposed. You authorize us to deduct these charges as accrued directly from the account balance. You also agree to pay additional reasonable charges we may impose for services you request which are not contemplated by this agreement. You agree to be liable for any account deficit resulting from charges or overdrafts, whether caused by you or another authorized to withdraw from this account, and the costs we incur to collect the deficit including, to the extent permitted by law, our reasonable attorney's fees.

DEPOSITS – Any items, other than cash, may not be accepted for deposit, and if accepted will be given provisional credit only until collection is final. Unless otherwise disclosed, interest on non-consumer accounts will be paid only on collected funds, subject to minimum balance or other limitations, if any. We are not responsible for transactions initiated by mail or outside depository until we actually record them. All transactions received after

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our "daily cut-off time" on a business day we are open, or received on a day in which we are not open for business, will be treated and recorded as if initiated on the next following business day that we are open.

WITHDRAWALS – Unless otherwise clearly indicated on the account records, only you may withdraw or transfer all or any part of the account balance at any time on forms approved by us. We may charge against your account a check, even though payment was made before the date of the check, unless you have given us written notice of the postdating. The fact that we may honor withdrawal requests that overdraw the finally collected account balance does not obligate us to do so, unless required by law. Withdrawals will first be made from collected funds, and we may, unless prohibited by law or our written policy, refuse any withdrawal request against uncollected funds, even if our general practice is to the contrary. We reserve the right to refuse any withdrawal or transfer request that is attempted by any method not specifically permitted, which is for an amount less than any minimum withdrawal requirement, or which exceeds any frequency limitation. Even if we honor a nonconforming request, repeated abuse of the stated limitations (if any) may eventually force us to close this account. We will use the date a transaction is completed by us (as opposed to the day you initiate it) to apply the frequency limitations. On interest-bearing accounts other than time deposits, we reserve the right to require at least seven days' written notice before any withdrawal or transfer.

ACH AND WIRE TRANSFERS – This agreement is subject to Article 4A of the Uniform Commercial Code in the state in which you have your account with us. If you originate a fund transfer for which Fedwire is used, and you identify by name and number a beneficiary financial institution, an intermediary financial institution or a beneficiary, we and every receiving or beneficiary financial institution may rely on the identifying number to make payment. We may rely on the number even if it identifies a financial institution, person or account other than the one named. You agree to be bound by automated clearing house association rules. These rules provide, among other things, that payments made to you, or originated by you, are provisional until final settlement is made through a Federal Reserve Bank or payment is otherwise made as provided in Article 4A-403(a) of the Uniform Commercial Code. If we do not receive such payment, we are entitled to a refund from you in the amount credited to your account and the party originating such payment will not be considered to have paid the amount so credited. If we receive a credit to an account you have with us by wire or ACH, we are not required to give you any notice of the payment order or credit.

OWNERSHIP OF ACCOUNT AND BENEFICIARY DESIGNATION – You intend these rules to apply to this account depending on the form of ownership and beneficiary designation, if any, specified on the application. We make no representations as to the appropriateness or effect of the ownership and beneficiary designations, except as they determine to whom we pay the account funds. The HSA is an Individual Account and therefore is owned by one person.

AMENDMENTS AND TERMINATION – We may change any term of this agreement. For other changes we will give you notice in writing or by any other method permitted by law. We may also close this account at any time upon reasonable notice to you and tender of the account balance personally or by mail.

STATEMENTS – You must examine your statement of account with "reasonable promptness". If you discover (or reasonably should have discovered) any unauthorized payments or alterations, you must promptly notify us of the relevant facts. If you fail to do either of these duties, you will have to either share the loss with us, or bear the loss entirely yourself (depending on whether we exercised ordinary care and, if not, whether we substantially contributed to the loss). The loss could be not only with respect to items on the statement but other items forged or altered by the same wrongdoer. You agree that the time you have to examine your statement and report to us will depend on the circumstances, but that such time will not, in any circumstance, exceed a total of 20 days from when the statement is first made available to you.
You further agree that if you fail to report any unauthorized signatures, alterations, forgeries or any other errors in your account within 60 days of when we make the statement available, you cannot assert a claim against us on any items in that statement, and the loss will be entirely yours. This 60 day limitation is without regard to whether we exercised ordinary care. The limitation in this paragraph is in addition to that contained in the first paragraph of this section.

SET-OFF – You each agree that we may (without prior notice and when permitted by law) set off the funds in this account against any due and payable debt owed to us now or in the future, by any of you having the right of withdrawal, to the extent of such persons' or legal entity's right to withdraw. If the debt arises from a note, "any due and payable debt" includes the total amount of which we are entitled to demand payment under the terms of the note at the time we set off, including any balance the due date for which we properly accelerate under the note. You agree to hold us harmless from any claim arising as a result of our exercise of our right of set-off.

AGENCY (POWER OF ATTORNEY) DESIGNATION – Agents may make account transactions on the behalf of the parties, but have no ownership or rights at death unless named as beneficiary(ies).

PRIVACY PROTECTION NOTICE

PERSONAL INFORMATION PRIVACY PROTECTION NOTICE – At National Advisors Trust, protecting the privacy and confidentiality of your personal information is important to each of us. We value your business and the trust you put in us. To offer you the financial products and services you seek, we collect, maintain, and use information about you on a routine basis. To help you better understand how your personal information is protected, we are providing you with the following statement describing our practices and policies with respect to the privacy of customer information. In the event you terminate your customer relationship with us, or become an inactive customer, we will continue to adhere to the policies and practices described in this notice.

INFORMATION WE COLLECT –As your trusted financial institution, we collect, retain, and use personally identifiable financial information (or nonpublic personal information) about individual customers, allowed by law, to provide products and services to our customers. We may collect nonpublic information from such sources as:

- applications or other forms;
- information about your transactions with us, our affiliates, or others, and
- information we receive from a consumer reporting agency.

HEALTH INFORMATION WE COLLECT – we may collect personally identifiable health information, like medical reports, for certain products or services that we offer. We do not share personally identifiable health information with anyone except as may be requested or required in connection with processing a product or service you have requested or as required or permitted by law.

USE OF INFORMATION – We use personal information in ways that are compatible with the purposes for which we originally requested it. For example, we will use the information you give us to process your requests and transactions, to provide you with additional information about products and services or to evaluate your financial needs. We collect and use personal information to administer our business and deliver quality service to you. This may include advising you about our products or services, those of our affiliates, those of our business partners and other opportunities that we believe may interest you.

INFORMATION WE SHARE – We may disclose nonpublic personal information about you with our corporate affiliates and other nonaffiliated third parties under certain circumstances to provide account services. Any nonpublic information shared is conducted in strict adherence to applicable law. We do not disclose any nonpublic personal information about you to anyone, except as permitted by law.

WHO RECEIVES INFORMATION AND WHY – We do not disclose any nonpublic personal information about our customers, or former customers, to anyone, except as permitted by law. We may exchange such information with our affiliates and certain non-affiliated third parties (under limited circumstances) to the extent permissible under law to service your account, report to credit bureaus, manage risk, and other financial services related activities.

ACCURACY AND RIGHT TO CORRECT – We continually strive to maintain complete and accurate information about you and your accounts. Should you ever believe that our records contain inaccurate or incomplete information about you, please notify us. We will investigate your concerns and correct any inaccuracies.

HOW WE PROTECT YOUR INFORMATION – We restrict access to your personal and account information to those employees who need to know that information to provide products or services to you. We maintain physical, electronic, and procedural safeguards that comply with federal standards to guard your nonpublic personal information. Your confidence in us is important and we want you to know that your personal and account information is safe.

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NATIONAL ADVISORS TRUST

Application & Beneficiary Designation Form

Please complete this Application & Beneficiary Designation Form and return to your Plan Service Provider (PSP) indicated on the back of this form.

ACCOUNT HOLDER INFORMATION (Please Print)

*REQUIRED FIELD

*Name: (First)______________________________(MI)__________(Last)______________________________

*Preferred Mailing Address: ☐ Home Address ☐ Mailing Address

*Home Address:______________________________

*City:______________________________ State:__________ Zip Code:______________________________

*Mailing Address (if different from above):______________________________

*City:______________________________ State:__________ Zip Code:______________________________

*Home Phone: ______________________________ Work Phone:______________________________

Email Address: ______________________________*Date of Birth:______________________________

*Social Security Number: ______________________________

*Mother's Maiden Name (security purposes only): ______________________________*City & State of Birth: ______________________________

EMPLOYER INFORMATION

Employer Name: ______________________________

Address:______________________________

City:______________________________ State:__________ Zip Code:______________________________

Is your HSA funded through Cafeteria Plan deductions? Yes ☐ No ☐

ELIGIBILITY INFORMATION (You must check yes on each question below to be eligible for an HSA)

☐ Yes ☐ No I am currently, or will be upon the date of my first contribution, an eligible individual as described in the Custodial Account Agreement.

☐ Yes ☐ No 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.

☐ Yes ☐ No I am currently, or will be upon the date of my first contribution, covered by a High Deductible Health Plan (HDHP) that meets the qualifications detailed in the Custodial Account Agreement.

HDHP INFORMATION

HDHP Carrier:______________________________ Check One: ☐ Single Coverage ☐ Family Coverage

Plan Effective Date:______________________________Deductible Amount: $ ______________________________

ADOPTION AGREEMENT

This application is for the establishment of my individually owned Health Saving Account at the Custodian displayed on the reverse side of this form. 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 reverse side 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.

Signature of Account Holder: ______________________________ Date:______________________________

(Beneficiary Designation on Opposite Side)

Application & Beneficiary Designation Form *(cont.)*

Pursuant to Section VI of the Custodial Account Agreement, you are authorized to designate one or more individuals as your Account Beneficiary(ies). For each designated person below, include their address, city, state, zip, social security number (if known) and relationship to you in the space provided. You must also designate a percentage of your remaining account (if any) to be distributed to that individual.

Note: All percentages must add up to 100%.

PRIMARY BENEFICIARY(IES)

Name: ______ %______

Address:______ City:______ State:______ Zip:______

SSN:______ Relationship:______

Name: ______ %______

Address:______ City:______ State:______ Zip:______

SSN:______ 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(ies) designated below. In the event that no beneficiary can be located, your account balance (if any) will be distributed to your estate.

CONTINGENT BENEFICIARY(IES)

Name: ______ %______

Address:______ City:______ State:______ Zip:______

SSN:______ Relationship:______

Name: ______ %______

Address:______ City:______ State:______ Zip:______

SSN:______ Relationship:______

Note: Special rules apply in certain states if a married individual does not select his/her spouse as beneficiary. If you reside in a community or marital property state and designate a person other than your spouse as beneficiary, you must obtain authorization from your spouse. It is the responsibility of the Account Holder to ensure that the individual(s) designated as beneficiary(ies) are legally authorized to act in that fashion.

ELECTRONIC FUNDS TRANSFER

I hereby authorize my Plan Service Provider (PSP) to facilitate Electronic Funds Transfer (EFT) between my Health Savings Account (HSA) and my Personal Bank Account as indicated below. These EFT transactions will be facilitated by the PSP but will be initiated by the Custodian. EFT transactions will be either a withdrawal from my Personal Bank Account for subsequent deposit into my HSA or will be a withdrawal from my HSA for subsequent deposit into my Personal Bank Account.

Account Type: ☐ Checking Account ☐ Savings Account

Bank Name: ______

Address:______ City:______ State:______ Zip:______

Bank Routing Number (First 9 numbers on bottom of check): ______

Bank Account Number (Second set of numbers): ______

DEBIT CARD PAYMENT METHOD

☐ I hereby request a *my*SourceCard® MasterCard® debit card as an alternate distribution method from my HSA account. I understand that additional fees may apply. (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.

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

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

CUSTODIAN

National Advisors Trust
10881 Lowell Ave., Suite 100, Overland Park, KS 66210
Phone: (877) 527-3476 • Fax (913) 498-0798 • E-Mail: info@nationaladvisorstrust.com

CUSTODIAL ACCOUNT MANAGER

DataPath Financial Services, Inc.
P.O. Box 55068 • Little Rock, AR 72215
Web: www.myHSAtoday.com • Email: info@myHSAtoday.com

PLAN SERVICE PROVIDER

Name:______ Serial Number: ______
Address:______
Web: ______ E-mail: ______
Phone: ______ Fax: ______

MARKETING REPRESENTATIVE

Name:______

Serial Number (to be completed by the PSP):______

Official Use Only Account Number:______ Date:______

Notes: ______ Signature: ______

HSA Today
Save today for a healthy future

Health Savings Account Application Instructions
(To be completed by the Employee)

- **Note: If any of the below information changes, DFS will contact the Plan Service Provider via email.**

Completing the Application

Items that are required to be completed by the employee are listed below. If the application is received by the TPA\PSP and the required information is missing, the TPA can return the application to the employee to complete OR the TPA can contact the employee and fill in the missing information, but it must be initialed and dated by whomever makes the change to the signed document. You can also have the employee to email or fax over the missing information and attach it to the application. If DFS receives the application and information is missing, the TPA can email the changes to DFS and that would be sufficient to attach to the incomplete application. As long as our files show a hard copy of the completed information so we can compare the completed documents to what is available online.

1. Name (required)
2. Home Address (required)
3. Mailing Address (optional) – If the mailing address is listed, they will need to check which address is preferred (home or mailing)
4. Home Phone number – if they do not have a home phone number, work number will be sufficient but there must be some type of contact for this person. Or use cell number. **A contact number is Required**.
5. Work Phone number – optional unless there is no home contact number
6. Email Address (optional)
7. Date of Birth (required)
8. Social Security Number (required)
9. **Drivers License Number**
   a. If this field is blank, contact the employee, if their dl number is the same as their ssn, please fill in the ssn and initial; or
   b. Fill in valid driver license number; or
   c. If this field is blank and they do not have a driver's license at all, fill in "**non-licensed**" and initial.
10. **Mother's Maiden Name and City of Birth**
    a. If we can get one or the other that would be sufficient; although it would be great if they completed both fields on the application.
11. Eligibility Information – required

12. HDHP Information – we need the coverage type, plan effective date and the deductible amount. We need this information to calculate the excess earnings for the year. **(required)**
13. Adoption Agreement – there **<u>must</u>** be a signature and signature date. If there is no signature on the original application, it will be returned to the Plan Service Provider.

<u>Beneficiaries</u>

There can be additional documents added if there is not enough space for the employee to fill in all of their beneficiaries. The percentage location must be completed as we need to know how the funds are to allocated. All Primary must equal 100% and all contingent must equal 100%.

- **Note: If the employee wants the fund to be allocated in a manner that is not listed on the application, they can add an additional document to the application as to how they want their funds allocated and that would be added in our files with the application. Make sure they <u>sign and date</u> the attached document.**

- **Example 1: Employee has a primary listed with 100% and two contingents. If the primary is deceased, they want all of the 100% to go to the first contingent and none to the second contingent unless the first contingent is not available. For situations like this, they need to put in writing exactly what they want done and on the application they must state See Attached Document.**

- **Example 2: Employee has two primaries with 50% each. If one is deceased they may want all to go to second primary or they may want 50% to go to the second primary and the other 50% to go to their estate. They must state exactly what they want if it is not going to follow the standard setup on the form.**

<u>Electronic Funds Transfer</u>

This is **<u>not</u>** required. This is needed if the employee wants a direct deposit to this account for reimbursements or if they want us to draft post tax dollars from this account. Otherwise, they will receive a check for their disbursements for a $3.00 check fee. This check fee will be charged to the HSA Account.

<u>Review Application Status</u>

1. Applications are entered into the HSA System by the Plan Service Provider.
2. When the HSA benefit is entered, please change the status to **"Application Received"**.
3. Fax or email the application to 501.687.1409 or support@myhsatoday.com
4. The application can only be approved by DFS.

5. The PSP can then mail out Welcome Letters and any additional information needed to the employee once the application has been approved. It is not required to use the Welcome Letters created by the HSA System. You can edit the original letter in Document Manager or use letter from another source.

Other:

If your employees are uploaded from the administration system and the addresses are missing, please email DFS (support@myhsatoday.com) the employer name, and DFS will correct it for you. You will **not** need to re-enter the addresses, if they were in the admin system.

Please call DFS, at 888-665-1264, if you have any questions.

HSA INFORMATION CHANGE FORM

This form should be used in the event you wish to make a change to your Name, Address, Beneficiary Designation, or your Personal Bank Account.

ACCOUNT HOLDER INFORMATION (PLEASE PRINT)			☐ **CHECK IF NEW ADDRESS**
Name:			
Address:	**City:**	**State:**	**Zip:**
Account Number:	**SSN:**	**Date of Birth:**	
Mother's Maiden Name: (Security purposes only)			

ACCOUNT HOLDER NAME CHANGE(PLEASE PRINT)
Please remit a copy of your marriage license or divorce decree that has the new name printed.
Old Name:
New Name:

BENEFICIARY(IES) INFORMATION (COMPLETE ONLY WHEN MAKING A BENEFICIARY DESIGNATION CHANGE)

The Beneficiary(ies) listed in this section will replace the previously assigned beneficiary(ies), if any.
Refer to Section IV of the Custodial Account Agreement for more information on Beneficiary Designation.

PRIMARY BENEFICIARY(IES)

☐ ADD ☐ REMOVE
Name: ______________________ Account %: ______________
Address: ______________________ City:__________ State:________ Zip:__________
SSN: ______________________ Relationship: ______________

☐ ADD ☐ REMOVE
Name: ______________________ Account %: ______________
Address: ______________________ City:__________ State:________ Zip:__________
SSN: ______________________ Relationship: ______________

CONTINGENT BENEFICIARY(IES)

☐ ADD ☐ REMOVE
Name: ______________________ Account %: ______________
Address: ______________________ City:__________ State:________ Zip:__________
SSN: ______________________ Relationship: ______________

☐ ADD ☐ REMOVE
Name: ______________________ Account %: ______________
Address: ______________________ City:__________ State:________ Zip:__________
SSN: ______________________ Relationship: ______________

☐ ADD ☐ REMOVE
Name: ______________________ Account %: ______________
Address: ______________________ City:__________ State:________ Zip:__________
SSN: ______________________ Relationship: ______________

DEPENDENT INFORMATION (COMPLETE ONLY WHEN ADDING DEPENDENTS)

Please attach additional sheet(s) if more space is needed. Enter name of dependent that needs to be added. Cannot remove a dependent at this time as they are tied to an expense that has been entered.

GAINED DEPENDENT(s)

☐ ADD
Name: ____________________
Address: ____________________ City: __________ State: __________ Zip: __________
SSN: ____________________ Relationship: ____________________

☐ ADD
Name: ____________________
Address: ____________________ City: __________ State: __________ Zip: __________
SSN: ____________________ Relationship: ____________________

☐ ADD
Name: ____________________
Address: ____________________ City: __________ State: __________ Zip: __________
SSN: ____________________ Relationship: ____________________

NEW PERSONAL BANK ACCOUNT INFORMATION (PLEASE PRINT)

Bank Name:

Address: **City:** **State:** **Zip:**

Routing Number: **Account Number:**

☐ **Checking or** ☐ **Savings**

Signature of Account Holder: **Date:**

Mail to your Plan Service Provider:

____

____

____

____

Plan Service Provider can forward a copy of the form to:

HSAToday, DataPath Financial Services, Inc., P.O. Box 55068, Little Rock, AR, 72215

HSA Information Change Form Instructions

(To be completed by Employee)

This form must be completed by employee and submitted to the PSP for change in the HSA system. A copy must be forwarded to DFS to keep on file.

Account Holder Information

1. Name (required)
2. Address (required) – new address if "check if new address" is selected
3. Account Number (required for verification)
4. SSN (required)
5. Date of Birth (required)
6. Mother's Maiden Name (required)

Account Holder Name Change – remit a copy of marriage license or divorce decree with the new name printed on it.

1. Old Name (required)
2. New Name (required)

Beneficiary Information – employee can submit in written form if the standard form does not allow the employee to allocate their funds appropriately.

1. Primary Beneficiary – must add up to 100%, use additional paper if more space is needed.
2. Contingent Beneficiary – must add up to 100%, use additional paper if more space is needed.

Dependent Information – employee can enter dependents that are not beneficiaries. Need dependent information to enter expense information properly.

1. Enter name of dependent that needs to be added. Cannot remove a dependent at this time as they are tied to an expense that has been entered.

New Personal Bank Information

1. Bank Name (required)
2. Address (required)
3. Routing Number (required)
4. Account Number (required)

Authorized Signature

1. Account holder is to sign and submit form to PSP. PSP is to forward a copy of the document to DFS.
2. PSP must initial and date the form before submitting copy to DFS.

HSA Transfer Request Form

To request an HSA Transfer or Rollover from prior custodian to HSA*Today*, please complete this Form and Submit it to:

DataPath Financial Services
c\o National Advisors Trust Company, FSB.
P.O. Box 55068
Little Rock, AR 72215
Voice: 888-665-1264
Fax: 501-687-1409
Email: support@myhsatoday.com

PART I - ACCOUNT HOLDER INFORMATION (PLEASE PRINT)

Name:		**SSN:**
Address:		
City:	**State:**	**Zip:**
Account Number:		
Work Phone:	**Home Phone:**	
Email:		
Mother's Maiden Name (Security purposes only)**:**		**Date of Birth:**

PART II – TYPE OF REQUEST

Trustee to Trustee Transfer:	I currently have a Health Savings Account or MSA with another Trustee or Custodian and want to transfer the funds directly to National Advisors Trust. (***Proceed to Part III***)
HSA Rollover:	I have been issued a check in the amount of $__________________ and closed my HSA or MSA. I would like to rollover the funds to establish an HSA with National Advisors Trust. 1. I want to send my roll over monies via: ☐ **Check** – mail check to: DataPath Financial Services, P.O. BOX 55068, Little Rock, AR, 72215 ☐ **EFT Draft** from my personal bank account at this financial institution: Bank Name: ______________________________ Route Number: ______________________________ Account Number: ______________________________ Account Type: ☐ Checking ☐ Savings (***Answer the Rollover Qualification Questions below and then proceed to Part IV.***)
Rollover Qualification Questions	(For an eligible rollover, all questions must be answered "NO") Funds from an IRA or SIMPLE IRA may not be rolled over to an HSA. 2. Have more than 60 days elapsed since you received the distribution from the distributing MSA or HSA bank? ☐ **Yes** ☐ **No** 3. Did you receive any other distributions from the distributing MSA/HSA during the preceding 12 months, which you also rolled over? ☐ **Yes** ☐ **No**

PART III.A – TRANSFER INFORMATION

(Skip this section if you are completing an HSA rollover and have included a check for the rollover or requested we draft your personal account.)

This request is for a Trustee-to-Trustee transfer. The monies currently in a Health Savings Account (HSA) with another Trustee or Custodian are to be directly transferred to National Advisors Trust.

CURRENT MSA/HSA TRUSTEE/CUSTODIAN INFORMATION:

Institution Name:	
Phone:	
Address:	
City, State, Zip:	
Current MSA/HSA Account Number:	
Current Custodian Contact Name and Phone:	

TRANSFER INSTRUCTIONS

I ____, authorize ____ (current custodian) to

Directly transfer: _____ **All** or _____ **Part** of my account in the following manner. If partial transfer list Amount $_________________.

- ❑ Make a check payable to the Bank as Custodian for the above account and mail to:

  DataPath Financial Services
  C\o National Advisors Trust Company, FSB.
  Health Savings Account Department
  P.O. Box 55068
  Little Rock, AR 72215

- ❑ Previous Custodian Transfer funds to New Custodian via ACH to an account provided by DataPath Financial Services. Please call 888-665-1264 to receive the account information.
  Amount to transfer $_______________

This transfer ____ **Will** ____ **Will Not** close my account.

PART IV – ACCOUNT HOLDER SIGNATURE

Sign Here for Trustee to Trustee Transfer

I authorize the transfer of the HSA assets in the manner described above, and certify that all of the information provided by me may be relied upon by the Trustee or Custodian.

Account Holder – Signature Required:	**Date:**

RULES AND CONDITIONS APPLICABLE TO ROLLOVER

GENERAL INFORMATION

A rollover is a way to move money or property from a Medical Savings Account (MSA) or existing Health Savings Account (HSA) to a Health Savings Account. The Internal Revenue Code (IRC) Limits how many rollovers may be taken, how quickly rollovers must be completed, and how the Trustee or Custodian must report the transaction. By properly completing this form you are certifying to the Trustee or Custodian that you have satisfied the rules and conditions applicable to your rollover and that you are making an irrevocable election to treat the transaction as a rollover.

ROLLOVER

1. Timelines

The funds you receive from a MSA or HSA must be deposited into an HSA within 60 days after you receive them. When counting the 60 days, include weekends and holidays. There are generally no exceptions to the 60-day rule and the IRS cannot grant extensions. Receipt generally means the day you actually have the funds in hand. For example, the 60 days would begin on the day you pick up the check from the Trustee or Custodian or you receive the check in the mail.

2. Twelve-Month Restriction

You are entitled to one distribution per year per HSA which may be rolled over. Twelve (12) months must pass after receipt of one distribution which you rollover before you may take another distribution from the same HSA to rollover. The focus is on distributions out of an HSA. An HSA is created by executing a plan agreement, not by depositing a contribution into a separate investment with an existing MSA or HSA.

You are entitled to rollover the same assets only once in a twelve (12) month period. Twelve (12) months must elapse between the time you receive a distribution of the assets to be rolled over and the time you receive another distribution of those same assets for rollover purposes.

For Internal Use Only: Accepting HSA Custodian

Our organization agrees to serve as the new Custodian for the account of the above named individual, and as Custodian, we agree to accept the assets being transferred.

National Advisors Trust Company, FSB.
P.O. Box 55068
Little Rock, AR 72215
Voice: 888-665-1264
Fax: 501-687-1409
Email: support@myhsatoday.com

_______________________________ _______________
Authorized Signature of New Custodian **Date**

IRA/FSA/HRA Transfer Request Form

To request an IRA Transfer to your HSAToday™ Account, please complete this Form and Submit it to:

DataPath Financial Services
c\o National Advisors Trust Company, FSB.
P.O. Box 55068
Little Rock, AR 72215
Voice: 888-665-1264
Fax: 501-687-1409
Email: support@myhsatoday.com

PART I - ACCOUNT HOLDER INFORMATION (PLEASE PRINT)

Name:		**SSN:**
Address:		
City:	**State:**	**Zip:**
HSA*Today*™ Account Number:		
Work Phone:	**Home Phone:**	
Email:		
Mother's Maiden Name (Security purposes only)**:**		**Date of Birth:**

PART II – TYPE OF REQUEST

Select All that Apply	Follow the Directions Below
IRA Transfer Request: ☐	I currently have a Health Savings Account with National Advisors Trust and want to do a one-time transfer from my IRA (*Individual Retirement Account*). (***Proceed to Part III***)
FSA Transfer Request: ☐	I currently have a Health Savings Account with National Advisors Trust and want to transfer my Health FSA Balance to my **HSA*Today*™** Account. (***Proceed to Part IV***)
HRA Transfer Request: ☐	I currently have a Health Savings Account with National Advisors Trust and want to transfer my Health Reimbursement Account Balance to my **HSA*Today*™** Account. (***Proceed to Part V***)

Note: If you do not have an HSA Account, please complete an HSA Account Application and submit along with this transfer request form.

PART III. – IRA TRANSFER INFORMATION

This request is for a Trustee-to-Trustee transfer. The monies currently in an Individual Retirement Account (IRA) with another Trustee or Custodian are to be directly transferred to National Advisors Trust.

CURRENT IRA CUSTODIAN INFORMATION:

Institution Name:	
Phone:	
Address:	
City, State, Zip:	
Current IRA Account Number:	
Current Custodian Contact Name and Phone:	

TRANSFER INSTRUCTIONS

I ______________________________________, authorize my IRA Custodian ____
(HSA Account Owner, Please Print Name) (IRA Custodian Name, Please Print Name)

to make a one-time direct transfer from of my IRA to my Health Savings Account Custodian:

Amount to Transfer: $_________________.

IMPORTANT: Amount to transfer is limited HSA annual contribution Limit.

Make a check payable to ("**HSA*Today*™**") for the above account and mail to: **(Please include a copy of this form)**

DataPath Financial Services
c\o National Advisors Trust Company, FSB.
Health Savings Account Department
P.O. Box 55068
Little Rock, AR 72215

PART III. – ACCOUNT HOLDER SIGNATURE

Sign Here for Trustee to Trustee Transfer

I authorize the transfer of the IRA assets in the manner described above, and certify that all of the information provided by me may be relied upon by the Trustee or Custodian.

Account Holder – Signature Required:	**Date:**

PART IV. – HEALTH FSA TRANSFER INFORMATION

This request is for a Health FSA transfer. The monies currently in a Health FSA (FSA) with your Employer are to be directly transferred to National Advisors Trust on your behalf by a check from your Employer.

CURRENT EMPLOYER-SPONSERED HEALTH FSA PLAN INFORMATION:

Employer Name:	
Phone:	
Address:	
City, State, Zip:	
HR Contact Name and Phone:	

TRANSFER INSTRUCTIONS

I ____, authorize my Employer ____
(HSA Account Owner, Please Print Name) (Employer Name, Please Print Name)

to make a one-time direct transfer from of my Health FSA to my Health Savings Account Custodian:

Amount to Transfer: $________________.

IMPORTANT:	Amount to transfer is limited to your Health FSA Balance as of September 21, 2006, or if less, your Health FSA balance on the date of the transfer.

Make a check payable to ("**HSA*Today*™**") for the above account and mail to: **(Please include a copy of this form)**

DataPath Financial Services
c\o National Advisors Trust Company, FSB.
Health Savings Account Department
P.O. Box 55068
Little Rock, AR 72215

PART IV. – ACCOUNT HOLDER SIGNATURE

Sign Here for Health FSA Transfer

I authorize the transfer of my Health FSA Balance in the manner described above, and certify that all of the information provided by me may be relied upon by the Trustee or Custodian.

Account Holder – Signature Required:	**Date:**
Employer – Signature Required:	**Date:**

PART V. – HEALTH REIMBURSEMENT ACCOUNT (HRA) TRANSFER INFORMATION

This request is for a Health Reimbursement Account (HRA) transfer. The monies currently in a HRA with your Employer are to be directly transferred to National Advisors Trust on your behalf by a check from your Employer.

CURRENT EMPLOYER-SPONSERED HRA PLAN INFORMATION:

Employer Name:	
Phone:	
Address:	
City, State, Zip:	
HR Contact Name and Phone:	

TRANSFER INSTRUCTIONS

I ____, authorize my Employer ______________________________________
(HSA Account Owner, Please Print Name) (Employer Name, Please Print Name)

to make a one-time direct transfer from of my Health Reimbursement Account (HRA) to my Health Savings Account Custodian:

Amount to Transfer: $________________.

IMPORTANT: Amount to transfer is limited to your HRA Balance as of September 21, 2006, or if less, your HRA balance on the date of the transfer.

Make a check payable to ("**HSA*Today*™**") for the above account and mail to: **(Please include a copy of this form)**

DataPath Financial Services
c\o National Advisors Trust Company, FSB.
Health Savings Account Department
P.O. Box 55068
Little Rock, AR 72215

PART V. – ACCOUNT HOLDER SIGNATURE

Sign Here for HRA Transfer

I authorize the transfer of my Health Reimbursement Account Balance in the manner described above, and certify that all of the information provided by me may be relied upon by the Trustee or Custodian.

Account Holder – Signature Required:	**Date:**
Employer – Signature Required:	**Date:**

RULES AND CONDITIONS APPLICABLE TO ROLLOVER

GENERAL INFORMATION

President George W. Bush signed the Health Opportunity Patient Empowerment Act of 2006 on December 20, 2006. The law, part of the Tax Relief and Health Care Act of 2006, provides new opportunities for health savings accounts (HSA) participants to build their funds.

HSA provisions of the Act include:

1. One Time rollovers from Health FSAs and HRAs into HSAs through 12/31/2011

Employers can transfer funds from Flexible Spending Arrangements (FSAs) or Health Reimbursement Arrangements (HRAs) to an HSA. The one time tax free rollover of Health FSA and/or HRA amounts (a Qualified HSA Distribution) is the balance in the FSA or HRA as of September 21, 2006, or if less, the balance as of the date of the transfer. The provision is limited to one distribution with respect to each Health FSA or HRA of the individual. The Qualified HSA Distribution is treated as a rollover contribution for HSA purposes; therefore, it does not decrease the amount that may be contributed to the HAS during the year.

If an individual does not remain an eligible individual for the 12 months following the month of the contribution, the transferred amount is included in income and subject to a 10 percent additional tax.

2. One time transfer from IRAs to HSAs

The new rules allow for a one-time contribution to an HSA of amounts distributed from an Individual Retirement Arrangement (IRA). The contribution must be made in a direct trustee-to-trustee transfer. The IRA transfer will not be included in income or subject to the early withdrawal additional tax.

Unlike Health FSA/HRA transfers, the IRA transfer is not treated as a rollover contribution. Thus any amounts transferred from the IRA to the HSA during the year reduce the maximum amount that may otherwise be contributed to the HSA during the year. Generally, only one transfer may be made during the lifetime of an individual.

If an individual electing the one-time transfer does not remain an eligible individual for the 12 months following the month of the contribution, the transferred amount is included in income and subject to a 10 percent additional tax.

For Internal Use Only: Accepting HSA Custodian

Our organization agrees to serve as the new Custodian for the account of the above named individual, and as Custodian, we agree to accept the assets being transferred.

National Advisors Trust Company, FSB.
P.O. Box 55068
Little Rock, AR 72215

____ ____________________
Authorized Signature of New Custodian **Date**

HSA *Today* Save today for a healthy future ™

HSA *Today*™ Expense Detail and Request for Distribution

Account Holder Information

Name of Account Owner:		HSA Account Number:	
Address:		Social Security Number:	
City:		Daytime Phone Number:	
State:	Zip:	Date of Birth:	
Employer:		Date of Death (if applicable):	

Check One:
- ☐ **Please enter my receipts in the claims vault. No reimbursement requested. Complete 1, ONLY.**
- ☐ **Please enter my receipts in the claims vault. Yes, reimbursement requested. Complete 1 and 2.**
- ☐ **Reimbursement ONLY, No claims to submit for claims vault at this time. Complete 2, ONLY.**
- ☐ **Send Refund to my Employer.**

1 Expense Detail

If this distribution from your HSA is for a Qualified Medical Expense and you want your Plan Service Provider to Certify that the expenses are qualified for tax filing purposes, then please supply medical expense information below. Use a copy of this form if you need more space.

Receipt Attached	Date of Service	Patient Name	Relationship	Provider	Description of Service	Amount
☐						
☐						
☐						
☐						
☐						
					Total	

2 Reason for Distribution (check one) and Payment Instructions

- ☐ Normal Qualified Distribution
- ☐ Non-Qualified Distribution
- ☐ Disability
- ☐ Withdraw Contribution and send to my Employer
- ☐ Withdrawal Excess Contributions & Earnings for Tax Year ____________
- ☐ Close Account and Distribute Remaining Balance
- ☐ Death
- ☐ Other ____

Requested HSA Withdrawal:

$ ____________________

- ☐ Mail check to me (a fee of **$1.50** for each check will apply)
- ☐ Deposit into my personal bank account on file.
- ☐ **New** Account or **Change** Account:

Route #: ____________________________

Account #: ____________________________

Bank Name: ____________________________

Account Type: ☐ Checking ☐ Savings

- ☐ NO Expense Detail
- ☐ New Expense Detail

Account Holder's Certification For Disbursement

I certify that this distribution requested from my accounts was incurred by me (and/or my spouse and/or eligible dependents), was not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible Section 213(d) medical expenses and should be treated as a Tax-Free Distribution under my HSA. I will not use the expense reimbursed through this account as deductions or credits when filing my individual income tax return. Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

HSA Owner's Signature: ____ **Date**: _______/_______/________

Send Request for Disbursements: **Fax to:** PSP Fax Number **Mail to:** PSP Mailing Address

Distribution Request Form Instructions
(To be completed by Employee)

- **Note: If any of the below information changes, DFS will contact the Plan Service Provider via email or phone.**
- **We can email you the word document when you are ready to add your TPA information at the bottom of the form.**

Completing the Request for Distribution Form

Items that are required to be filled out by the employee are listed below.

Account Holder Information

1. Name of Account Owner (required)
2. HSA Account Number (required)
3. Address (required)
4. Social Security Number (required)
5. City (required)
6. Daytime Phone Number (required)
7. State (required)
8. Date of Birth (required)
9. Zip (required)
10. Date of Death (if applicable)- this needs to be filled in by the spouse or beneficiary of who withdrawals the money from the account, if the account holder is deceased.
11. Employer (required)

Check One

- ❑ Please enter my receipts in the claims vault. No reimbursement requested. Complete 1, ONLY.
- ❑ Please enter my receipts in the claims vault. Yes, reimbursement requested. Complete 1 and 2.
- ❑ Reimbursement ONLY, No claims to submit for claims vault at this time. Complete 2, ONLY.
- ❑ Send Refund to my Employer (new item added, this is a private account, if the employer has submitted contributions to an account and they must be removed, the account holder must request the funds and select this option for it to go back to the employer. PSP must notify DFS of the issue so we can be sure to verify the information on the form.)

Expense Detail

Employee can enter expense detail. It is not required for reimbursement.
Employee can enter expense detail without attaching the receipts. This is self-attesting.
Employee can enter expense detail and NOT request the full amount in the claims vault.

Reason for Distribution and Payment Instructions

Check one:

- ❑ Normal Qualified Distribution
- ❑ Non-Qualified Distribution (will not need to fill out Expense Detail)
- ❑ Disability
- ❑ Withdraw Contributions and send to my Employer ((new item added, this is a private account, if the employer has submitted contributions to an account and they must be removed, the account holder must request the funds and select this option for it to go back to the employer. PSP must notify DFS of the issue so we can be sure to verify the information on the form.)
- ❑ Death
- ❑ Withdrawal Excess Contributions & Earnings for Tax Year (Please make sure to list a tax year)
- ❑ **Close Account and Distribute Remaining Balance (this option is no longer available for selection, only listed to view old claims that were entered as closed prior to the NEW close account process)**
- ❑ Other

Enter the Amount Requested for Withdrawal

- Check either
  - ❑ Mail check to me (**a fee of $3.00 for each check will apply**)
  - ❑ Deposit into my personal bank account on file.
  - ❑ New Account or Change Account
    - o List bank account name, routing number, account number and account type: checking or savings

Additional Assistance with Payment Options and Expense Detail

Option 1

Employee wants to request funds from HSA account but has not submitted receipts.

- The form can be completed with only the "Requested HSA Withdrawal" amount. No expenses to enter. If employee marks it as Qualified, they must keep their receipts themselves in case they are audited.

Option 2

Employee wants to request funds from HSA account with receipts attached.

- Complete request portion and enter expenses in the expense detail section.
- Employee can attach receipts.
- Similar to the process of doing FSA claim processing.
- If expenses are entered, the expense can be seen in the claims vault

Option 3

Employee wants to turn in receipts, but do not request an amount.

- Complete expense detail on form but do NOT enter an amount in the "Requested HSA Withdrawal" section.
- TPA can enter the expense detail without entering a request date or request amount and release the batch.
- Since the request and the expense are not linked together as in the 125 system, if the employee decides to request funds at a later date, the TPA does not have to go back and search for the prior expense detail form in the system and then enter an amount on it. See option 1 to complete the Request.

Option 4

If the employee has turned in a request amount and for any reason the TPA needs to put the requested amount on hold. Check the hold checkbox.

- If there is no requested amount or date, the request cannot be put on hold.
- Expenses cannot be put on hold, technically claims vault. If expenses do not meet certification requirements, the PSP will be able to set a portion of the expense amount ineligible.

Account Holder's Certification for Disbursement

Please read the information provided, sign and date.

HSA CONTRIBUTION / DEPOSIT SLIP

Account Holder Information

Name: ____________________

Social Security Number: ____________________

Account Number: ____________________

TAX YEAR TO APPLY __________ **(Required)**

CHECK __________ $ __ __ , __ __ __. __ __

❑ Post Tax DATE: ____ / ____ /______

Be sure to include your HSA account number on your check.

Make payable to **HSA*Today*** & Mail to: **DataPath Financial Services**
PO BOX 55068
Little Rock, AR 72215

HSA CONTRIBUTION / DEPOSIT SLIP

Account Holder Information

Name: ____________________

Social Security Number: ____________________

Account Number: ____________________

TAX YEAR TO APPLY __________ **(Required)**

CHECK __________ $ __ __ , __ __ __. __ __

❑ Post Tax DATE: ____ / ____ /______

Be sure to include your HSA account number on your check.

Make payable to **HSA*Today*** & Mail to: **DataPath Financial Services**
PO BOX 55068
Little Rock, AR 72215

Be sure to include your HSA account number on your check.

HSA CONTRIBUTION / DEPOSIT SLIP

Account Holder Information

Name: ____________________

Social Security Number: ____________________

Account Number: ____________________

TAX YEAR TO APPLY __________ **(Required)**

CHECK __________ $ __ __ , __ __ __. __ __

❑ Post Tax DATE: ____ / ____ /______

Be sure to include your HSA account number on your check.

Make payable to **HSA*Today*** & Mail to: **DataPath Financial Services**
PO BOX 55068
Little Rock, AR 72215

HSA*Today* ™
Save today for a healthy future

*my*SOURCECARD™ ENROLLMENT FORM

PERSONAL INFORMATION - ENROLLMENT CANNOT BE PROCESSED WITHOUT REQUIRED INFORMATION

Name:
(Required) (Print exactly as you would like it to appear on your card) (21 characters maximum, including spaces)

Date of Birth: __ - __ - ____
(Required)

Social Security Number: ___ - __ - ____
(Required)

Email Address:
Required for electronic statements (If not provided, a paper statement will be sent and additional fees may apply.)

Street Address:
(26 characters maximum, including spaces)

City:
(17 characters maximum, including spaces)

State/Prov.:

Zip Code: _____ - ____

Phone Number: ___ - ___ - ____

Mother's Maiden Name:

Dependant's Name:
(Required only for additional cards. Additional fees may apply.)

X ______________________________ Date ______________

Enrolling Employee's Signature • *Please read the Agreement before signing*
By signing above I indicate my acceptance of the terms and conditions of this Agreement, as well as receipt of the *my*SourceCard™ Cardholder Agreement and acceptance of the terms contained therein.

EMPLOYER INFORMATION - OPTIONAL

Employer's Name: ______________________________

MYSOURCECARD™ ADDENDUM

The *my*SourceCard™, a MasterCard® Debit Card (the "Card"), is offered to you as an additional method of distribution from your Health Savings Account ("HSA" or "Account") as indicated in Article IV of the HSA*today*™ Custodial Account Agreement. By signing, using or accepting the Card, you agree that your use of the Card will be governed by the terms and conditions of this Addendum, the Cardholder Agreement supplied with the Card, and by the terms and conditions of the HSA*today*™ Custodial Account Agreement.

How the Card Program Works. As an owner of an HSA, you have been provided the Card for your use of purchasing goods and services at various MasterCard® acceptance locations. The Card may not be used to obtain a cash advance from any merchant, bank, or ATM. You agree to save all receipts in the event of an IRS audit and hereby understand that the acceptance of this Card at a merchant does not in any way make a statement to the qualification of such charge as a Tax-Free or Normal distribution from the Account. You agree that the amounts charged on your Card will be paid by electronically deducting the corresponding amount from your Account and you authorize such deductions to be made in accordance with this Agreement. Your total purchases may not exceed the available cash on deposit, excluding Investment Account Funds, in your Account at the time of purchase.

Fees. Your Plan Service Provider will establish the account setup and monthly fees associated with your HSA. You PSP will establish if such fees will be deducted from your account, paid by your employer, or paid by you with non-HSA funds.

HSA Debit Card Process

- **Listed below is the HSA\Debit Card Process**
- **Note: If any of the below information changes, DFS will contact the Plan Service Provider via email or phone.**

Completing the Application

Personal Information

Items that are required to be completed by the employee are listed below.

1. Name (required)
2. Date of Birth (required)
3. Social Security Number (required)
4. E-mail address (required for electronic notifications)
5. Street Address (required)
6. Phone Number (required)
7. Mother's Maiden Name (required)
8. Dependent's Name (Only for additional cards. *Additional fees may apply*)
9. Enrolling Employee's Signature (required)

Employer Information (Optional)

1. Employer's name (optional)

MYSOURCECARD™ ADDENDUM

For Employee Informational Purposes

Debit Card Application Process

1. Employee receives and completes the application
2. Employee forwards application to TPA
3. Applications are entered into the HSA System (HSA Benefit | Edit | See Debit Card) by the Plan Service Provider.
4. The system will automatically update the purse value on an approved card application entry each night.
5. The balance on the HSA\Debit Card will be the balance that is available in the account holders' HSA account. The balance on the debit card does not include the 25.00 minimum HSA Account balance.
6. Example: HSA Balance is listed as $100.00; the balance on the card will be $75.00.

Other:

HSA\Debit Card Fees – Please refer to the fee schedule www.myhsatoday.com/nat

HSA TODAY™ ACCOUNT HOLDER SCHEDULED POST TAX DRAFT

This form authorizes your Plan Service Provider to facilitate regularly scheduled electronic transfer of funds from your personal account on file with my PSP for contribution to your Health Savings Account ("HSA").

HEALTH SAVINGS ACCOUNT ELIGIBILITY INFORMATION: In order to establish an HSA, you must be classified as an "Eligible Individual" under IRC Section 223, its sub-sections and applicable rulings and provisions, collectively called the "Code". You are eligible for an HSA ***ONLY*** if you can meet the following requirements: (1) you are covered by a high deductible health plan ("HDHP"); (2) you are not covered by another health plan that is not a HDHP; (3) you are not able to be claimed as a dependent by another taxpayer; (4) you are not entitled to benefits under Medicare.

General Information

Name: (please print) ______________________________

Date of Birth: ______________ Social Security Number: ______________

Daytime Phone: ______________ email address: ______________

Address: ______________________________

City: ______________ State: ________ Zip: ______________

Employer Name: ______________________________

HSA CONTRIBUTION ELECTION

❑ I authorize a monthly Post tax contribution of $______________ to my HSA via EFT (Electronic Funds Transfer) from the bank account listed below. Please complete bank account information or attach a voided check:

Name of Bank: ______________________________

Name on Account: ______________________________

Bank ABA/Route No.: ______________________________

Bank Account No.: ______________________________

❑ Funding Frequency: (Choose only one)

❑ One Time on:______ / _____ / _______

❑ Monthly beginning on _______ /________ (month/year) and will continue on a regular monthly schedule on the **❑1st** or **❑ 15th** of each month until notified by me in writing.

I understand that I must provide at least seven (7) days' notice in order to facilitate any change in my HSA contribution schedule.

The monthly contribution amount may not exceed 1/12 of the annual deductible plus any Catch-Up contributions allowed.

Attention MSA or HSA account holders with accounts at other financial institutions, please remember that the total annual contributions to all accounts may not exceed federally mandated limits.

Required Signature

I hereby authorize DataPath Financial Services to make automatic withdrawals from my personal bank account listed above to be transferred by EFT (Electronic Funds Transfer) into my Health Savings Account. I understand this HSA contribution will not be processed until all paperwork is signed and returned to my Plan Service Provider (PSP). I further understand that I am responsible for all contributions made to my HSA.

Signature: ______________________________ Date: ______________

Plan Service Provider

PSP NAME.......... - ADDRESS - Little Rock, AR 72204

Phone: (000) 000-0000 / Fax: (000) 000-0000 / Web: www.webaddress.com / Email: info@myemail.com