COPFCU HSA APPLICATION & AGREEMENT

HSA Owner Information Check if Amendment ▶ ☐

Name | Social Security Number | Date of Birth

Address | Home Phone Number | Mobile Phone Number

City/State/Zip | Sex (Male or Female) | Primary Email Address

Beneficiary Information

Primary Beneficiary

Name | Relationship

Social Security Number/Tax I.D. Number | Date of Birth

Address

City/State/Zip

☐ **Primary Beneficiary** ☐ **Contingent Beneficiary**

Name | Relationship

Social Security Number/Tax I.D. Number | Date of Birth

Address

City/State/Zip

☐ **Primary Beneficiary** ☐ **Contingent Beneficiary**

Name | Relationship

Social Security Number/Tax I.D. Number | Date of Birth

Address

City/State/Zip

☐ **Primary Beneficiary** ☐ **Contingent Beneficiary**

Name | Relationship

Social Security Number/Tax I.D. Number | Date of Birth

Address

City/State/Zip

I, the undersigned HSA Owner, hereby designate the above as my beneficiary(ies). If primary or contingent is not indicated, primary will be assumed. Unless otherwise requested herein, each payment made pursuant to this designation: (a) shall be paid in equal shares to the primary beneficiary(ies) who are living at the time of my death; or (b) if no primary beneficiary(ies) shall be living at the time of my death, such payment shall be made in equal shares to the contingent beneficiary(ies) who are then living; or (c) if no primary beneficiary(ies) or contingent beneficiary(ies) shall be living at the time of my death, such payment shall be made to my estate. If my spouse receives this HSA as a result of my death, this HSA will become his or her HSA as of the date of my death. If a non-spouse beneficiary receives this HSA as a result of my death, this HSA terminates as of the date of my death and the assets in this HSA become payable to such beneficiary. I have the right to change this designation at any time.
Spousal consent: (for use in community or marital property states) I agree to my spouse's naming a primary beneficiary other than myself. I transfer (transmute) any community property interest I have in this HSA into the separate property of my spouse. I agree to seek the advice of a legal or tax professional, as needed.

Signature of Spouse: _____ Date: _____

Deposit Information

TYPE OF DEPOSIT: ☐ Regular for tax year _____
☐ Rollover from an HSA
☐ Rollover from an Archer Medical Savings Account (MSA)

AMOUNT OF DEPOSIT: $ _____

Name and Address of Custodian

COPFCU
959 W. 8th St.
Cincinnati, OH 45203
(513) 381-2677 1 (800) 810-0221

Adoption and Acknowledgement

This Application to Participate is made part of the Health Savings Account Agreement. I acknowledge receipt of the HSA Agreement establishing my Health Savings Account, the Disclosure Statement, and a copy of this Application. I certify that, to the best of my knowledge, the information provided on this form is true and correct and it may be relied on by the Custodian. I agree to seek the advice of a legal or tax professional, as needed. The Custodian has not provided me with any legal or tax advice, and I assume full responsibility for this transaction. I will not hold the Custodian liable for any adverse consequences that may result from this transaction.

Signature of HSA Owner | Date

Signature of Custodian | Date

Revocation

This HSA may be revoked within seven days of the date of its establishment. See the Disclosure Statement for more information. Such revocation may be made only by written notice mailed or delivered to:

COPFCU
Name of Financial Organization
959 W. 8th. St.
Address
Cincinnati, OH 45203
City/State/Zip
HSA Department | (513) 381-2677
Contact Person | Phone Number

For Office Use Only