HSA BANK®
National Leader in Health Savings Accounts.
A Division of Webster Bank, N.A., Member FDIC

AUTHORIZED SIGNER FORM

Instructions: Please complete the fields below and return this form to:
HSA Bank, P.O. Box 939, Sheboygan, WI 53082-0939, FAX: (877) 851-7041. *For assistance, call (800) 357-6246.*

Accountholder's Personal Information - *all fields required unless otherwise indicated*

First Name **MI** **Last Name**

Social Security # - - **OR** **Account #** **(8 digits, from your statement)** **Birth Date (mm/dd/yyyy)** / /

Authorized Signer Information - *all fields required (P.O. Box not accepted)*

Since regulations require that only one individual own a Health Savings Account, the accountholder may want his/her spouse and/or third party to be an authorized signer to write checks or use his/her MBI card.

I (accountholder), as named above, designate the following individual as an additional authorized signer on my Health Savings Account.

Authorized Signer First Name **MI** **Authorized Signer Last Name**

Social Security # - - **Birth Date** / /

Street Address (No P.O.Box)

City **State** **Zip**

Home Phone # - -

☐ I would like to order 50 duplicate checks and 10 deposit tickets with my authorized signer's name. The cost of $7.95 will be deducted from my account.

Starting Check Number For This Order

To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify and record information that identifies each person on an account. What this means to you: When you add an authorized signer to your account we will need you to provide your authorized signer's name, street address, date of birth and other information that will allow us to identify your authorized signer. We may also ask to see your authorized signer's driver's license or other identifying documents. Your authorized signer will be added to your account upon verification of their identity.

Signatures

If you wish to designate an authorized signer on your account, please complete all of the required fields above. If you are unable to provide all of the required information on your authorized signer, they will not be added to your account. You hereby designate the following individual as an authorized signer on your Health Savings Account. By designating an authorized signer on your account, you authorize the person designated above as "Authorized Signer" to transact business with and give instructions to HSA Bank regarding your health savings account; make deposits or withdrawals by any means acceptable to HSA Bank, including paper and electronic methods such as ACH and Internet-generated transactions; receive and have access to account information, including account balances and transactions; endorse any instruments such as checks, orders or other documents for the payment of funds; and to otherwise serve as agent for your HSA Bank health savings account.
You specifically authorize HSA Bank, as custodian of your HSA, to rely upon this authorization and designation until such time, if any, that HSA Bank receives a written revocation of this authorization, and has had a reasonable time to act upon the revocation. You understand that you are responsible for ensuring that your authorized signer reads and understands the HSA Bank Account Documents which have been provided to you.
You hold harmless and indemnify HSA Bank against any claims against or losses HSA Bank may suffer arising out of HSA Bank's reliance on this authorization, and release HSA Bank from any liability arising from such reliance, unless otherwise prohibited by law. You understand that you bear sole responsibility for any tax consequences that result from any actions taken by the authorized signer regarding your account.
NO PRESENT OR FUTURE OWNERSHIP OR RIGHT OF SURVIVORSHIP IS GIVEN TO THE AUTHORIZED SIGNER BY THIS AUTHORIZATION. UPON NOTICE TO HSA BANK OF YOUR DEATH, THIS AUTHORIZATION TERMINATES, AND RIGHTS TO FUNDS IN YOUR ACCOUNT WILL BE TRANSFERRED TO YOUR BENEFICIARIES. IF YOU DID NOT NAME A BENEFICIARY, YOUR ACCOUNT BALANCE WILL ONLY BE PAYABLE TO YOUR ESTATE.

Accountholder Signature **Date** **Authorized Signer** **Date**