



HEALTH SAVINGS ACCOUNT (HSA) APPLICATION

To avoid processing delays, please complete all fields on the application — shaded fields are optional, starred fields (*) are required.

Mail your completed application (and opening deposit, if applicable) to:
Exante Bank HSA, P.O. Box 169049, Duluth, MN 55816

Or fax both sides of this form to: 800-765-6766 and mail opening deposit, if applicable, separately to:
Exante Bank, P.O. Box 271629, Salt Lake City, UT 84127-9872

PART 1: PERSONAL INFORMATION — ACCOUNT HOLDER

*Social Security #

*First Name		*Middle Initial	*Last Name	
*Street Address (cannot be a P.O. box)			Mailing Address (if different than street address)	
*City			City	
*State	*ZIP	State	ZIP	
*Date of Birth			*Home phone # with area code	
*Mother's maiden name (or other password for security purposes — 6 to 10 letters)				
Work phone # with area code and extension			E-mail address	

PER THE USA PATRIOT ACT:

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 who opens an account. When you open the account, we will ask for your name, street address, date of birth and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

Form of Identification (check one): <input type="checkbox"/> Driver's License <input type="checkbox"/> State ID <input type="checkbox"/> Passport	Identification #	State of issuance
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PART 2: HIGH-DEDUCTIBLE HEALTH PLAN (HDHP)/MEDICAL PLAN INFORMATION

*Medical Insurance Company or Carrier	*Medical Insurance Plan or Group #
HDHP Member Identification # (you may find this on your ID card)	*HDHP start date
*Who is covered? (check one): <input type="checkbox"/> Individual <input type="checkbox"/> Family [Individual + Dependent(s)]	
*Are you enrolling in an HSA through your employer? (check one): <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide your employer's name	

PART 3: REQUEST FOR ADDITIONAL DEBIT CARD (OPTIONAL)

You will receive a Health Savings Account MasterCard® Debit Card. If you wish to request a Health Savings Account CardSM for use by an authorized user — either your spouse or another eligible dependent — please complete the section below.

Authorized User's First Name	Authorized User's Middle Initial	Authorized User's Last Name
Authorized User's Date of Birth	Authorized User's Social Security #	
If address is same as Account Holder, check here <input type="checkbox"/>		
Authorized User's Street Address		
Authorized User's City	Authorized User's State	Authorized User's ZIP

PART 4: BENEFICIARY INFORMATION (OPTIONAL)

If you do not designate otherwise, your estate will be the beneficiary of your HSA upon your death. To designate an alternative beneficiary, please complete a Designation of Beneficiary form, available on ExanteBankHSA.com or request one from customer service, toll-free at 1-866-234-8913.

PART 5: REQUIRED SIGNATURES (Please read before signing)

- I understand the eligibility requirements for deposits made to my Health Savings Account (HSA) and state that I qualify to make deposits to this account. I have reviewed this application, the Health Savings Account (HSA) Schedule of Fees and Charges, HSA Custodial and Deposit Agreement, Privacy Notice and Card Agreement. By signing below, I understand and agree to be bound by the terms and conditions that apply to this HSA as outlined in these documents.
- I assume complete responsibility for:
 1. Determining my eligibility for an HSA each year I make a contribution.
 2. Ensuring all contributions made to my account are within the limits set forth by the tax laws.
 3. Any tax consequences of contributions (including rollover contributions) and distributions.
- I authorize Exante Bank to provide information about my HSA, including my account number, to my employer (if applicable), and those acting on behalf of my employer or Exante Bank (if applicable), in connection with the establishment and maintenance of my HSA.
- I acknowledge that my employer, and others acting on behalf of my employer (if applicable), may provide information on my behalf to establish and maintain my HSA.
- I understand that my monthly account statements will be made available to me electronically. I agree to notify Exante Bank if I wish to have statements mailed to my home address.
- I certify that the information provided in this application is true and complete.

X _____ *Account Holder – Signature Required _____ *Date

IMPORTANT: We cannot process this application without your signature.

PART 6: OPENING DEPOSIT

Opening deposit enclosed with application (if applicable) (check one): Yes No Amount: \$ _____

If you are an individual mailing an opening deposit for your own HSA, please write your name and social security number on the check. If you are an employer mailing contributions for multiple employees, please fill out an employer contribution form.