

# ENROLLMENT FORM

## Instructions

1. Complete form to open a Health Savings Account (HSA). An HSA is a tax-advantage account if used for paying or reimbursing qualified medical expenses.
2. Associated Bank, N.A. is your HSA Custodian.
3. Forward completed form to your HR department for processing. **Fax completed form to 920-327-6545** or mail to **Associated Bank HSA, ATTN: MS 7004, PO Box 19097, Green Bay, WI 54307.**

## Accountholder Information (\*Required Fields)

<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>
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\*Name (Last, First)

MI

\*Social Security Number

<input type="text"/>	<input type="text"/>
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\*Birth date (MM/DD/YYYY)

\*Employee ID

<input type="text"/>	<input type="text"/>
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\*Residential Address (cannot be a PO Box)

\*Email Address

<input type="text"/>	<input type="text"/>
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\*Alternative Mailing Address, (if different than above can be a PO Box)

\*Mobile/Cell Phone Number

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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\*City

\*State

\*Zip Code

\*Secondary Phone Number

<input type="text"/>	<input type="text"/>
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\*Driver's License Number

\*Other ID (if DL information is not provided)

<input type="text"/>	<input type="text"/>	<input type="text"/>
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\*Driver's License Issue Date

\*State

\*Expiration Date

## A. Current Employer Information\*

Current Employers Name

Current Employers Address

<input type="text"/>	<input type="text"/>	<input type="text"/>
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City

State

Zip Code

Current Occupation

## B. Citizenship\*

### B1. What is your United States Citizenship Status:

US Citizen    Resident Alien    Non-Resident    Other (please explain in B1a)

B1a. If your citizenship status is other, please describe

### B2. What is your country of birth?

B3. Are you a citizen of any other countries?  Yes  No

Passport/National ID Number

Passport/National ID Issuer

Passport/National ID Issue Date

Passport/National ID Expiration Date

### B4. What is your country of permanent residence?

B4a. If other than U.S., please provide your physical address for your country of permanent residence.

B5. Do you have an address (physical, PO Box, etc.) in a country other than the U.S. or your country of citizenship?

Yes  No

B6. Do you currently or have you within the last three years occupied a high position in a foreign government?

Yes  No

B7. Do you have an immediate/close family member or close associate who currently occupies or within the last three years occupied a high position in a foreign government?

Yes  No

### Important Information About Procedures for Opening a New Account.

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. What this means: When you open an Account, we will ask for your name, 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. As part of the ongoing maintenance of your account we may require other information or documentation that allows us to identify you. You understand that your HSA may be closed if additional verification is not possible. Upon such closure, funds deposited in your HSA will be returned to you, less any fees or expenses chargeable against your HSA, or penalties or surrender charges associated with the early withdrawal of any savings instrument or other investment in your HSA account. Associated Bank shall not be liable for any tax consequences or tax withholdings you may incur as a result of the transfer or distribution of your assets.

## Beneficiary Designation

You can add or modify your beneficiary designations at any time. The paper beneficiary form can be found in our Participant Portal under forms or by contacting customer service at **800-270-7719**.

## Authorized Signer

You can add or modify your authorized signer at any time. The paper authorized signer form can be found in our Participant Portal under forms or by contacting customer service at **800-270-7719**.

### C. Election\*

I am enrolling in an HSA through my employer. I authorize my employer to deduct my HSA contributions from my pay and forward them to my HSA. (Please complete the section immediately below)

\*Indicate High Deductible Health Care Plan (HDHP) Coverage Level:  Self-only  Family/Other

\*Indicate if you are enrolled in an HDHP through your employer:  Yes  No

HSA Effective Date:

#### Note

Your employer may also contribute to your HSA that will apply to your maximum contribution allowed. You are solely responsible for determining whether contributions to an HSA exceed the maximum annual contribution limitation. You are also responsible for notifying the custodian of any excess contribution and requesting a withdrawal of the excess contribution together with any net income attributable to the excess contribution.

\*Indicate if you are enrolled in an HDHP through your employer:

\$  Employee Annual Contribution **or** \$  Per Pay Period Contribution

Your contributions will be withdrawn from your pay in each pay period. If your employer maintains a cafeteria plan that permits HSA contributions, your contributions will be made with pre-tax dollars. You may also make contributions outside of your employment. If you would like to contribute immediately, please complete an HSA Contribution Form and submit that form with your payment.

### Terms, Conditions and Signatures

#### Important Information about Electronic Payments

I authorize electronic debit and credit entries, if applicable, to my designated checking or savings account. I also authorize adjustments to these accounts for error corrections. This authorization will remain in effect until the termination of your HSA.

#### Important Information Regarding My Account Summary

I understand that account summaries are made available electronically and may be viewed at any time by logging into my account. I understand the Associated Bank Privacy Policy is also available online at [www.associatedbank.com/privacy](http://www.associatedbank.com/privacy).

#### Important Information Regarding Substitute W-9 Certification

Under penalties of perjury, I certify that: (1) the Social Security Number shown on this form is my correct taxpayer identification number and, (2) I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and (3) I am a U.S. citizen (including a U.S. resident alien).

#### Important Information Regarding Fees

Any applicable fees shall be deducted from my account. NOTE: Employer-sponsored plans may sometimes cover monthly maintenance fees or require lower minimum balances to avoid them; talk with your Human Resource benefits specialist for more information on your company's plan and pricing.

**Important Information Regarding Custodial and Investment Information**

I have read and understand the Associated Bank Health Savings Account Custodial Agreement and other related documents and agree to be bound by those terms and conditions. I understand the eligibility requirements for this HSA and I state that I am responsible for determining whether I qualify to make deposits to this HSA. I am responsible for:

- a. determining that I am eligible to make contributions to a HSA for each year I make a contribution;
- b. ensuring that all contributions are within the maximum limitations set forth by the tax laws, considering my coverage under a high deductible health plan;
- c. the tax consequences of any contributions (including rollover contributions) or distributions; and
- d. seeking the assistance of a qualified tax or legal professional to address any questions or concerns I may have about eligibility, contribution limitations, or the taxation of contributions or distributions from my HSA.

If I choose to select an investment allocation from the list of mutual funds, I will be solely responsible for direction of the investment of my HSA. I represent that I will carefully review investment information prior to making investment decisions and that I will seek assistance of a financial professional if I have questions about available investment options or how to select investments for my HSA. **Investment products offered are NOT deposits or obligations of, insured or guaranteed by Associated Bank or any bank or affiliate, are NOT insured by the FDIC or any agency of the United States, and involve INVESTMENT RISK, including POSSIBLE LOSS OF VALUE.**

I authorize Associated Bank and its agents to initiate permitted transfers, including contributions, to my HSA, as directed by me through the electronic account service features or as otherwise permitted under this HSA. Any such direction shall remain in effect until Associated Bank and its agents receive notice of a change to such directions via the electronic account service features or as otherwise permitted under this HSA.

I certify that the information provided by me on this Enrollment Form is accurate, and that I understand that I will receive a copy of the Associated Bank Health Savings Account Custodial Agreement, Patriot Act Disclosure, fee schedule and any amendments thereto to my mailing address listed above. I also acknowledge that I will receive the Associated Bank Privacy Policy. I assume sole responsibility for all consequences found in the Associated Bank HSA Enrollment Form and Associated Bank Health Savings Account Custodial Agreement. These are available on the HSA Participant Portal for review prior to receiving them at my mailing address. I understand that I may revoke the HSA on or before the seventh day after the date of establishment. I have not received any tax or legal advice from Associated Bank, and I will seek the advice of my own tax or legal professional to ensure my compliance with related laws. I release and agree to hold the Associated Bank harmless against any and all claims or losses arising from my actions.

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Accountholder Signature

Date