SelectAccount®

CONCORDIA PLAN SERVICES

HEALTH SAVINGS ACCOUNT APPLICATION

Employer Information - To be completed by the Employer

Employer Name _____

CPS ER# _____

City_____ State_____

Employer: Please process enrollment form online at SelectAccount.com

Account Holder's Information - Please complete and give to your Employer

Last Name: _____ First Name: _____Middle Initial: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Primary Phone: _____

SSN#: _____Date of Birth: _____

Health Coverage Information

Type of HDHP Coverage: ☐ Single ☐ Family

Effective Date of Health Coverage_____

Authorization For Electronic Deposit And Withdrawals

NOTE: HSA Reimbursements will be electronically deposited to this bank account when the HSA debit card is not used.

Bank Information:

☐ Checking or ☐ Savings Account

Bank Name: _____ Bank Phone Number: _____

Bank ABA Routing Number: __ __ __ __ __ __ __ __ __ Bank Account Number: _____

(The ABA routing number is the nine-digit number located in the bottom left corner of your check)

Beneficiary Designation

Your spouse will be your beneficiary. If you have no spouse, your estate will be your beneficiary. You can change your beneficiary designations at any time by signing into your account at SelectAccount.com and completing online. The Beneficiary Form can be found at SelectAccount.com or by contacting customer service at (651) 662-5065 or (800) 859-2144.

HSA & Investment Account Maintenance Fees

HSA Participant Fee - The fee will be deducted from your HSA balance monthly unless it is paid by your employer.
Investment Accounts are available for Base Balance funds in excess of $1,000.00. For all basic investment accounts a monthly Investment Account fee of $1.50 will be deducted from your investment account balance.

Signature

The Account Holder named above is establishing this health savings account (HSA) exclusively for the purpose of paying or reimbursing qualified medical expenses of the account holder, his or her spouse, and dependents. The account holder represents that, unless this account is used solely to make rollover contributions, he or she is eligible to contribute to this HSA; specifically, that he or she: (1) is covered under a qualified high deductible health plan (HDHP); (2) is not also covered by any other health plan that is not a qualified HDHP (with certain exceptions for plans providing preventive care and limited types of permitted insurance and permitted coverage); (3) is not entitled to benefits under Medicare (generally, has not reached age 65); and (4) cannot be claimed as a dependent on another person's tax return.

The Custodial Agreement for this account will be sent to you under separate cover.

_____ _____

HSA Account Holder Signature Date

HSA Custodian Information

P.O. Box 64193, St. Paul, MN 55164-0193 • SelectAccount.com • (651) 662-5065 or (800) 859-2144