

Resource Bank, Custodian
c/o Health Savings Administrators
10800 Midlothian Turnpike, Suite 240
Richmond, VA 23235
Phone: 888-354-0697 • Fax: 804-355-5375

Health Savings Account Enrollment Form

Group Enrollment

Office Use: Date ___/___/___
Cust# _____ - _____
RAN ___ - ___ - _____
RB# _____

Your Information

Social Security # _____ - _____ - _____ Date of Birth _____ - _____ - _____
First Name _____ MI _____ Last Name _____
Address _____ City _____ State _____ Zip _____
Daytime Phone # () _____ Email address _____
This Account is: Single Family
Spouse _____ Date of Birth _____ - _____ - _____

Form of Identification (*Required – Check the appropriate box and fill in the identification number from that document*)

Driver's License State ID Passport ID# _____ State Issued _____

Note: 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 for you: 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.

Insurance Information

Insurance Company Arkansas Blue Cross Blue Shield
Annual Insurance Deductible \$ _____
Insurance Effective Date _____ - _____ - _____

Employer Information

Employer Name _____
Mailing Address _____
City State Zip _____

Health Savings Account Options

You may choose either the Vanguard® Mutual Funds or the Resource Bank Health Savings Debit Card to be used in conjunction with your Health Savings Account.

I choose to invest in the Vanguard® Funds. I have received and read the current prospectus (available at www.Vanguard.com) for the fund(s) in which I am investing, and agree to be bound by its (their) terms. I recognize that the performance data featured represents past performance, which is no guarantee of future results. Share price, yield and return will vary and I may have a gain or loss when I sell my shares. I have authority and the legal capacity to purchase mutual fund shares, am of legal age and believe each investment is suitable for me. It is my responsibility to obtain and read the prospectus of any fund into which I exchange. My fund selection is indicated below: (Choose from the Vanguard® choices on our web page):
Fund Name: _____ Symbol _____

I choose to apply for the Resource Bank Debit Card. I have read and received Resource Bank Privacy Notice and Debit Card Account Agreement and Disclosure and will be subject to the terms that have been provided to me. I authorize the Financial Institution to make any investigation of my credit, either directly or through any agency. I understand that the Financial Institution will retain this application and any other credit information, even if this Debit Card is not granted. I agree not to use the Debit Card in any illegal activity.

Securities offered through The Vanguard Group®, Inc. Security products: **Not insured by FDIC or any Federal Government Agency; May Lose Value; Not a Deposit of or Guaranteed by the Bank or any Bank Affiliate.**

Vanguard and The Vanguard Group are registered trademarks of The Vanguard Group, Inc.

Terms and Fees

The undersigned agrees to the following provisions:

1. I hereby appoint Resource Bank (Custodian) Health Savings Administrators (Administrator) as administrator of my Health Savings Account and I agree to the following fees. I recognize that my employer may pay some or all of these fees. Should I terminate my employment, I will be responsible for payment of all prevailing fees. In the event of non-payment, Health Savings Administrators is authorized to deduct them from my account.

Terms and Fees Continued

2. I authorize Resource Bank (Custodian) Health Savings Administrators (Administrator), to on my behalf for all transactions, including the payment from my account of any separate fees which may be charged by the agent or custodian.
3. Account maintenance fee: .00125 per quarter on the investment balance.
4. I certify that I am covered by a qualified High Deductible Health Plan (HDHP) as defined by the Internal Revenue Code (Code), I am not covered by a health plan, other than a HDHP, which provides any of the same benefits as the HDHP, I am not entitled to benefits under Medicare, and I may not be claimed as a dependent on another person's tax return.
5. I authorize Health Savings Administrators, LLC to pay all reimbursement requests submitted by me from my custodial HSA account.
6. I am responsible for determining my eligibility for making contributions to my HSA and for ensuring that those contributions are within the limits set forth by the Code.
7. I am responsible for all tax consequences of any contributions and/or distributions.
8. I have received a copy of the Application and the Health Savings Account Custodial Account Agreement. I agree to all terms and conditions of this Agreement. I understand that the terms and conditions that apply to this HSA are contained in this Application and the Agreement. I agree to be bound by those terms and conditions.

Beneficiary Information

The following individual(s) or entity shall be my primary and/or contingent beneficiary(ies). If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary beneficiary. If more than one primary beneficiary is designated and no distribution percentages are indicated, the beneficiaries will be deemed to own equal share percentages in the account. Multiple contingent beneficiaries with no share percentage indicated will also be deemed to share equally. If primary or contingent beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining beneficiary(ies) shall be increased on a pro-rated basis. If no primary beneficiary(ies) survives me, the contingent beneficiary(ies) shall acquire the designated share of my account.

Name	Relationship	DOB	SSN	Primary or Contingent	% of benefit

Signature

Under penalties of perjury, I certify that the Social Security Number shown on page one of this application is my correct taxpayer identification number, I am a U.S. person (including a U. S. resident alien), and that (check appropriate box):


- I am not subject to backup withholding either because I am exempt from backup withholding, or because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or because, the IRS has notified me that I am no longer subject to backup withholding.
- I am subject to backup withholding

I understand the eligibility requirements for the type of HSA deposit I am making and confirm I qualify to make the deposit. I hereby hold Resource Bank, Health Savings Administrators, LLC and their officers, employees, agents and subcontractors harmless from any liability for effecting transactions and interpreting the tax status of all reimbursements. Purchases made with the Debit Card will be reported by the Bank as "normal distributions." I understand I should not use my debit card or checks for non-qualifying or non-medical purposes and that I am responsible for any IRS penalties. I understand that I am responsible for any and all tax consequences should I submit an HSA withdrawal form for any non-qualifying or non-medical transaction.

Signature _____ Date _____ - _____ - _____

Deposit Calculations

One Time Set Up Fee	\$ 15.00
Annual Administration: \$42.00 annually - May be payroll deducted @\$3.50/mo.	
Current Deposit – Indicate Year of Contribution _____ (required)	\$
Total of fees and deposit	\$

NOTE: Please make check payable to Resource Bank 

Please mail this form, along with your check, to:

Health Savings Administrators - 10800 Midlothian Turnpike, Suite 240 - Richmond, VA 23235