

Toll Free: (800) 662-1113
 Fax: (844) 560-6754
 P.O. Box 258886
 Oklahoma City, OK 73125
 Website: americanfidelity.com
 Email: WG-AcctAdmin-HSA@americanfidelity.com

HEALTH SAVINGS ACCOUNT Application and Custodial Agreement

| PERSONAL INFORMATION | | | | |
|--------------------------------|------------|--|---------------------|--|
| Name* | | | SSN* | |
| Physical Address* | | | DOB (mm/dd/yyyy)* | |
| City, State, Zip* | | | Marital Status | <input type="checkbox"/> Single <input type="checkbox"/> Married |
| Mailing Address (if different) | | | Driver's License #* | |
| City, State, Zip | | | Issuing State* | |
| Home Phone | Work Phone | | Cell Phone | |
| Email address* | | | | |

Important Information about Procedures for Opening a New Account: ***Required fields**

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.

| HEALTH PLAN INFORMATION | | | | |
|--|---|---|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you covered by an HSA qualified high deductible plan (HDHP)? (If you answer no, you are not eligible to establish an HSA.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you covered by any other non-permitted health plan (i.e. Health FSA, spouse's non-HDHP medical plan)? | |
| Carrier Name | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you covered by Medicare? | |
| Effective date of HDHP | _____ | Yearly Deductible | \$ _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you claimed as a dependent on another person's tax return? |
| Type of Coverage | <input type="checkbox"/> Individual <input type="checkbox"/> Family | If you answered yes to any of the questions above, you are not eligible to establish an HSA. See IRS Publication 969 for specific information. See americanfidelity.com . | | |

| EMPLOYER INFORMATION | | | |
|----------------------|--|--------------------|--|
| Company Name* | | Contact | |
| Address | | Telephone Number | |
| City, St, Zip | | Date of Employment | |

| CONTRIBUTION INFORMATION | | | | |
|---|----------|----------------|--|--|
| Requested effective date for the HSA: _____ | | | | |
| (The requested effective date cannot be before the date this application is signed, effective date of coverage under the HDHP, or the date you are eligible to contribute to an HSA.) | | | | |
| Contribution | Annual | Per Pay Period | Pay Period (if applicable) | Annual maximums are updated each year by the IRS. For additional information on what may affect your annual allowable contribution(s) or to find out the allowable maximum contribution amount, please visit americanfidelity.com . |
| Employer | \$ _____ | \$ _____ | <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly | |
| Individual | \$ _____ | \$ _____ | | |
| Catch-up Contribution | \$ _____ | \$ _____ | | |

| REQUEST FOR ADDITIONAL DEBIT CARD (Optional) | | | |
|--|--|--------------------|--|
| Would you like a second debit card for use by an authorized user – either a spouse or an eligible dependent*- at no additional fee? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| *Dependent must be 18 years or older. **Required field for additional card | | | |
| Name** | | Relationship | |
| Social Security #** | | DOB (mm/dd/yyyy)** | |
| A MasterCard will automatically be mailed to your home address shown above. The debit card can be used with merchants with a valid medical merchant code. By requesting a secondary debit card, you are agreeing that the secondary debit card is subject to the HSA custodial agreement, all other conditions of the account, and all law governing HSA accounts. | | | |

| BENEFICIARY INFORMATION | | | | |
|-------------------------|--|--------------|--------------------------|------------|
| Name | | Relationship | <input type="checkbox"/> | Primary |
| Address | | DOB | <input type="checkbox"/> | Contingent |
| City, St, Zip | | SSN | ___% | Percent |
| Name | | Relationship | <input type="checkbox"/> | Primary |
| Address | | DOB | <input type="checkbox"/> | Contingent |
| City, St, Zip | | SSN | ___% | Percent |
| Name | | Relationship | <input type="checkbox"/> | Primary |
| Address | | DOB | <input type="checkbox"/> | Contingent |
| City, St, Zip | | SSN | ___% | Percent |

| Back-Up Withholding Certificate |
|--|
| I hereby certify under penalties of perjury that: The social security number shown on this form is my correct taxpayer identification number, I am a U.S. person (including a U.S. resident alien), and that (please check the appropriate box): |
| <input type="checkbox"/> I am not subject to withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service 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. |
| <input type="checkbox"/> I am subject to backup withholding. |

This application, when signed by me and accepted by American Fidelity - Administrator/Record keeper, constitutes my adoption of this application/ Custodial Agreement. By signing this agreement, I acknowledge and certify that I have received either in print or electronically (available anytime at americanfidelity.com), read and agree to the terms in the HSA Custodial Agreement, HSA Interest & Fee Schedule and Terms and Conditions of my Account and any amendments thereof.

 Signature of Account Holder Date Signature of Custodian Date