MyHSA Complete Application
Accountholder Terms & Conditions

Introduction – This form is used to open a new MyHSA account.

You want to open a MyHSA Health Savings Account ("MyHSA") at EPIC Retirement Plan Services (“EPIC RPS”). Your participation in the MyHSA program is conditioned on your acceptance of certain terms, which are identified below. Please read carefully before proceeding. Additional information is available through certain web links identified below, or by calling the MyHSA Help Desk at 800-57 MyHSA (800-576-9472). The MyHSA program is made available pursuant to an agreement between EPIC RPS, NBT Bank NA (“NBT”) and The Charles Schwab Bank ("CSB").

1. USE OF ELECTRONIC RECORDS AND COMMUNICATIONS

An "electronic record" means a record created, generated, sent, communicated, received or stored by electronic means. A "record" means any information that is **inscribed on a tangible medium or stored** in an electronic or other medium and is retrievable in perceivable form.
Participation in the MyHSA program is conditioned, in part, on your consent to have records provided or made available to you in connection with the MyHSA program in electronic form. By submitting this application, you hereby consent to receive electronic records.

Your consent to receive records in electronic form applies to all records that may be provided or made available at any time in connection with the MyHSA program, including but not limited to account statements, transaction records, fund prospectuses and annual reports.
You may withdraw that consent at any time. However, in such event EPIC RPS has the right to terminate your participation and require that you liquidate your MyHSA account and have your funds returned to you at the address on record. In order to withdraw your consent to receive electronic records or to provide updated information on how EPIC RPS can contact you electronically, you must contact us by telephone at 800-57 MyHSA (800-576-9472).

In addition to your consent to receive Electronic Records, you must acknowledge below each of the following terms and conditions. NOTE: Your participation in the Program is conditioned on your acknowledgement of each of these terms.

2. *MyHSA Health Savings Account Custodial Agreement*. You have read and you agree to the terms of the MyHSA Health Savings Account Custodial Agreement before you can enroll in the Program. The Custodial Agreement describes the rights and obligations of you, EPIC RPS, NBT and CSB with respect to your HSA. You will find the Custodial Agreement at www.myhsa.com under Forms.
3. *MyHSA Health Savings Account participant Fee Schedule*. You have read and agree to the terms of the MyHSA Health Savings Account Fee Schedule before you can enroll in the Program. You will find the Fee Schedule at www.myhsa.com under Forms tab.
4. *ABG Retirement Plan Investment Services Investment Policy Statement*. You have read the Investment Policy Statement. You can find the investment policy statement at www.myhsa.com under Forms tab.
5. *EPIC RPS's Privacy Policy with respect to use of your personal information*. You have read the Privacy Policy. You can find the privacy policy at www.myhsa.com under Forms tab.
6. *Investment Prospectuses*: You have read the prospectuses or prospectus profiles relating to the applicable Investment Options. You can find the prospectuses or profiles at www.myhsa.com under HSA tab/MyHSA Investment Options.

ACKNOWLEDGMENT AND CONSENT

By clicking "Yes" below, I hereby consent to receive Electronic Records and I acknowledge each of the above terms and conditions.

YES ☐

First Name:_____

Middle Initial:_____

Last Name:_____

Social Security Number:_____

Signature of Account Holder: _____ Date**:** _____

Broker ID: _____
(if applicable)

APPLICATION & BENEFICIARY DESIGNATION FORM

(PLEASE PRINT)

Please complete this Application & Beneficiary Designation Form for the EPIC Retirement Plan Services ("EPIC RPS") Health Savings Account Program and see return instructions on the next page.

ACCOUNT HOLDER INFORMATION		
Name: (First):	**(MI):**	**(Last):**
Social Security Number:	**Date of Birth:**	
Mailing Address:		
City:	**State:**	**Zip:**
Home Phone Number:	**Work Phone Number:**	
Email Address:		
HSA Qualified Health Plan Effective Date:		

EMPLOYER INFORMATION		
Employer Name:		
Address:		
City:	**State:**	**Zip:**

Eligibility Acknowledgement (you must check yes on the question below to be eligible for a Health Savings Account. If you answered no, please see your Benefits Administrator for more details)

☐ **Yes** ☐ **No** **I am currently an eligible individual as described in the Custodial Agreement into which this Application is incorporated. I understand that maintaining my eligibility is my responsibility and that EPIC RPS, NBT and The Charles Schwab Bank assumes that all contributions are made while I am eligible to participant in a qualified Health Savings Account.**

ADOPTION AGREEMENT

This application is for the establishment of my individually owned Health Saving Account. I understand that by signing this Application, I am acknowledging that I have received and reviewed the EPIC RPS Health Savings Account Custodial Agreement and agree to be bound by the terms of this agreement. In accordance with the terms and conditions of this agreement, I am requesting EPIC RPS to establish a Health Savings Account on my behalf with NBT and CSB as Custodian. I further understand and acknowledge that my Health Savings Account is not effective until it has been accepted by EPIC RPS. **I acknowledge that all contributions eligible for investment (as defined within the EPIC RPS Health Savings Account Individual Custodial Agreement) will be invested in a MetLife Guaranteed Fund until I have logged in to my account and set my contribution investment elections**. The information on this application is true and accurate to the best of my knowledge and I submit this form with full understanding and acceptance of the provisions contained within the Custodial Agreement. I also acknowledge that EPIC RPS is authorized to perform transactions on my account and all such transactions initiated by EPIC RPS should be treated as if initiated directly by me, the Account Holder.

Signature of Account Holder: _____ Date: _____

EPIC Retirement Plan Services, 456 Fulton Street, Suite 345, Attn: MyHSA Peoria, Il 61550
Help Desk at 1-800-576-9472 Monday-Friday 7:30 am to 5:00 pm CT **Fax** 1-800-688-4329

MyHSA Beneficiary Designation Form

ACCOUNT HOLDER INFORMATION		
Name: (First):	**(MI):**	**(Last):**
Social Security Number:	**Daytime Phone Number:**	
Mailing Address:		
City:	**State:**	**Zip:**
Email Address:		

Designation of Beneficiary (ies) – Please Print

I hereby revoke any Designation of Beneficiary I may previously have made in writing and or in electronic format.

Please list your primary and/or secondary beneficiary (ies), and the percentage of your account, which you would like each beneficiary to receive. If more than one beneficiary of a class is designated and no distribution percentages are identified, the beneficiaries will be deemed to own equal shares in the account. If you have designated a Trust as beneficiary, the entire benefit will be paid to the Trust (unless different percentages are designated. If you do not designate a beneficiary your entire benefit will be paid to your Estate. If any primary or secondary beneficiary dies before you do, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining beneficiaries shall be increased on a pro rata basis. If no primary beneficiary survives you, the secondary beneficiary (ies) shall acquire the designated share of your account. Completion of this form will supersede all prior designations. I understand that I may change or add beneficiaries at any time by completing and delivering the proper electronic or paper form to EPIC Retirement Plan Services ("EPIC RPS").

PRIMARY BENEFICIARY (IES) – Shares must equal 100%

Name _____ Name _____

Relationship _____ Relationship _____

Social Security Number _____ Social Security Number _____

Mailing Address _____ Mailing Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Percentage _____% Phone # _____ Percentage _____% Phone # _____

SECONDARY BENEFICIARY (IES) – Shares must equal 100%

Name _____ Name _____

Relationship _____ Relationship _____

Social Security Number _____ Social Security Number _____

Mailing Address _____ Mailing Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Percentage _____% Phone # _____ Percentage _____% Phone # _____

Spousal Consent: For Account Holders in Community Property or Marital Property States

Instructions to HSA Owner who resides in or establishes an HSA in a community or marital property state and names a beneficiary other than his or her spouse. It is your responsibility to determine whether spousal consent is necessary. Failure to have your spouse sign below may invalidate your beneficiary designation for a portion of your HSA. Please consult your tax or legal advisor if you have questions about this section.

Spousal Consent. I am the spouse of the HSA owner named on this application. I understand that my spouse is naming a beneficiary for the HSA other than myself. I approve and consent to the naming of said beneficiary and I hereby transmute (transfer) and partition any community property interest I have or would otherwise acquire in this HSA into the separate property of my spouse for disposition as my spouse sees fit. I understand the consequences of giving up my interest, and acknowledge that I have been advised to seek tax or legal advice regarding these consequences.

X _____ **X** _____

Signature of Spouse Date Signature of Witness Date

Account Holder Authorization

The above designations are subject to the Conditions of Beneficiary Designation listed below:

1. This designation is subject to all the terms and provisions listed above, and shall be effective only if received by EPIC RPS prior to the death of the named MyHSA account holder listed above.
2. This designation applies to the account holder's entire interest, in the account at the account holder's death.
3. I agree that the above information correctly reflects my desire to add or change death beneficiaries on my MyHSA Health Savings Account.

X _____ _____

Signature of Account Holder Date

MyHSA CONTRIBUTION AUTHORIZATION FORM

(PLEASE PRINT)

(Funds must be received prior to April 15th to qualify as a previous year contribution)
If you do not enter a contribution year below, your contribution will be processed in the year that we receive your form.

ACCOUNT HOLDER INFORMATION		
Name: (First):	**(MI):**	**(Last):**
Social Security Number:	**Daytime Phone Number:**	
Mailing Address:		
City:	**State:**	**Zip:**
Email Address:		

Contribution

Contribution is for calendar year ending:_____ **Contribution amount:**_____

If no calendar year ending year is entered above or if this form is received after the tax year deadline your contribution will be applied to the current tax year.

This contribution is via (check one):

☐ **Check by mail** Please make check payable to *Charles Schwab Bank*
On the check write "FBO #201892"
Mail (with form) to the address below

☐ **ACH Pull Initiated by EPIC Retirement Plan Services ("EPIC RPS").** (complete the banking information below)

****You must attach a copy of a voided check****

_____ **Name of Financial Institution**

_____ **Routing and Transit Number (9 Digits)**

(Authorization applies to checking accounts only)

_____ **Account Number**

I hereby authorize EPIC RPS to initiate and adjust a ONE TIME electronic transaction from the bank account named above to my EPIC RPS MyHSA account. These transactions are made through regional automated clearing house (ACH) associations and are subject to the operating rules and regulations of the National Automated Clearinghouse Association (NACHA).

All MyHSA account holders are responsible for assuring there are sufficient funds available in their account at the time of withdrawal. Where applicable, returned checks and ACH returns will incur additional fees. I certify that I am the owner of the account named above and that I have the legal right to provide this authorization.

MyHSA Account Holder Signature: _____ Date: _____

MAIL OR FAX A COPY OF THIS FORM TO:
EPIC RETIREMENT PLAN SERVICES
MyHSA DEPARTMENT
456 FULTON STREET, SUITE 345
PEORIA, IL 61602
FAX (800) 688-4329

If you have any questions please call 800-57MyHSA (800-576-9472).

ELECTRONIC FUNDS TRANSFER (EFT) CONTRIBUTION AUTHORIZATION FORM

(PLEASE PRINT)

Complete this form only if you wish EPIC Retirement Plan Services to initiate an electronic funds transfer (EFT) withdrawal from your personal bank account for purpose of MyHSA contribution on an ongoing MONTHY basis.

ACCOUNT HOLDER INFORMATION		
Name: (First):	**(MI):**	**(Last):**
Social Security Number:	**Daytime Phone Number:**	
Mailing Address:		
City:	**State:**	**Zip:**
Email Address:		

I am completing this form for the purpose of: (check all that apply)

- ☐ Creating a **NEW** monthly EFT
- ☐ Changing the amount of a current EFT
- ☐ Changing the financial institution of a current EFT
- ☐ Changing the contribution date of a current EFT
- ☐ **DISCONTINUING** a current EFT

☐ Check here if you would also like the bank account information below used for **direct deposit** of claims

I understand that contributions to my HSA account can not exceed the maximum statutory limits (for more information on these limits go to www.myhsa.com or call our help desk at 800-576-9472). I understand that trying to contribute more than the allowed maximum contribution to my HSA account could result in additional fees and tax penalties.

I hereby authorize EPIC Retirement Plan Services ("EPIC RPS"). to initiate and adjust MONTHLY electronic transactions from the bank account named below to my EPIC RPS MyHSA account. These transactions are made through regional automated clearing house (ACH) associations and are subject to the operating rules and regulations of the National Automated Clearinghouse Association (NACHA).

I understand this change will not be effective until the third business day following receipt of the completed form by EPIC RPS. All MyHSA account holders are responsible for assuring there are sufficient funds available in their account at the time of withdrawal. Where applicable, ACH returns will incur additional fees.

Please complete the appropriate sections (for a new EFT, complete all):

_____

Name of Financial Institution

_____

Routing and Transit Number (9 Digits)

_____

Account Number ***(Authorization applies to checking accounts only)***

Contribution Amount: $_____

Contribution Date: (select one)

_____ **1st Business Day of each Month**

_____**15th Business Day of each Month**

Start Date _____

I certify that I am the owner of the account named above and that I have the legal right to provide this authorization. This authorization remains in full force and effect until which time EPIC RPS has received written notification from me of its termination. Termination notification must be received at least ten (10) business days prior to your next ACH contribution.

Signature of Account Holder: _____ **Date:** _____

For New Bank Information: **A COPY OF A VOIDED CHECK MUST BE ATTACHED**

MAIL OR FAX A COPY OF THIS FORM TO:

EPIC RETIREMENT PLAN SERVICES
MyHSA DEPARTMENT
456 FULTON STREET, SUITE 345
PEORIA, IL 61602

FAX (800) 688-4329

If you have any questions please call 800-57MyHSA (800-576-9472).

AUTHORIZATION FOR DIRECT DEPOSIT (EFT) CLAIM/DISTRIBUTION PROCESSING (OPTIONAL)

(PLEASE PRINT)

Complete this form only if you wish EPIC Retirement Plan Services to initiate a direct deposit/electronic funds transfer (EFT) when reimbursing for a qualified medical expense paid out-of-pocket.

ACCOUNT HOLDER INFORMATION		
Name: (First):	**(MI):**	**(Last):**
Social Security Number:	**Daytime Phone Number:**	
Mailing Address:		
City:	**State:**	**Zip:**
Email Address:		

I hereby authorize EPIC Retirement Plan Services ("EPIC RPS") as program administrator to initiate credit entries as direct deposit claim reimbursements and to initiate, if necessary, debit adjustment entries made for any credit entry made in error to my account. These transactions are made through regional automated clearing house (ACH) associations and are subject to the operating rules and regulations of the National Automated Clearinghouse Association (NACHA).

I understand this change will not be effective until the third business day following receipt of the completed form by EPIC RPS. Where applicable, ACH returns will incur additional fees.

Please complete the appropriate sections (for new EFT, complete all):

_____

Name of Financial Institution

_____

Routing and Transit Number (9 Digits)

_____

Account Number *(Authorization applies to checking accounts only)*

I certify that I am the owner of the account named above and that I have the legal right to provide this authorization. This authority shall apply to all requests for claim reimbursements I submit to EPIC RPS under the Health Savings Account program. This authorization remains in full force and effect until which time EPIC RPS has received written notification from me of its termination. I agree to provide such notification of cancellation in such a manner as to afford EPIC RPS reasonable time to act on it. Failure to notify EPIC RPS in a timely manner could result in additional fees.

Signature of Account Holder: _____ **Date:** _____

****A COPY OF A VOIDED CHECK MUST BE ATTACHED****

MAIL OR FAX A COPY OF THIS FORM TO:

EPIC RETIREMENT PLAN SERVICES
MyHSA DEPARTMENT
456 FULTON STREET, SUITE 345
PEORIA, IL 61602

FAX (800) 688-4329

If you have any questions please call 800-57MyHSA (800-576-9472).