



HEALTH SAVINGS ACCOUNT (HSA) APPLICATION

Please be sure to complete all four pages of this form.

Date Account Opened _____ Account Number _____

ACCOUNT HOLDER INFORMATION: Please print clearly

Name	Social Security #	Date of Birth
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Mailing Address

City	State	Zip Code
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Street Address (not a P.O. Box)

City	State	Zip Code
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Home Phone	Work Phone	Fax
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E-mail Address

Primary Identification #*	State of Issuance	Expiration Date	Date of Issue
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Mother's Maiden Name

Employer Information

Name of Employer	Type of Business
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Employer's Address

City	State	Zip Code
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Phone Number	Fax	E-mail Address
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Insurance Carrier	Plan or Group Number
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Member Identification (Medical Plan)	Individual or Family Coverage
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*Driver's license number, passport, or state or government-issued photo identification showing residence.

BENEFICIARY INFORMATION

Please list your primary and/or secondary beneficiary(ies), and the percentage of your HSA 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 HSA. 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 HSA.

In the event of my death, I name as:

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
Share (Percent of holding) _____%	Share (Percent of holding) _____%

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
Share (Percent of holding) _____%	Share (Percent of holding) _____%

The above designations are subject to the following conditions:

1. These designations are subject to all terms and conditions of the Exante Bank Health Savings Account Custodial and Deposit Agreement and other documents you have received in connection with your HSA and will be effective only if received prior to the death of the person executing it.
2. These designations apply to the account holder's entire interest, if any, in account assets remaining undistributed at the account holder's death.
3. You must file any desired change of beneficiary(ies) in writing.

Spousal Consent

This section should be reviewed if you reside in a community or marital property state and you are married. Due to important tax consequences of giving up one's community property interest, individuals signing this section should consult with a legal or tax advisor.

Current Marital Status

- I am not married – I understand that if I become married in the future, I must complete a new Designation of Beneficiary form.
- I am married – I understand that if I chose to designate a primary beneficiary other than my spouse, my spouse must sign below.

I am the spouse of the above-named account holder. I acknowledge that I have received a fair and reasonable disclosure of my spouse's property and financial obligations. Due to the important tax consequences of giving up my interest in this account, I have been advised to see a tax professional. I hereby give the account holder any interest I have in the funds or property deposited in this account and consent to the beneficiary designation(s) indicated above. I assume full responsibility for any adverse consequences that may result. No legal or tax advice was given to me by Exante Bank.

Signature of Spouse

Date

Signature of Witness

Date

AUTHORIZATION FOR ACH DEBITS

I authorize Exante Bank to initiate debit entries, and adjusting entries thereto, through the regional automated clearing house ("ACH") associations, subject to the operating rules and regulations of the National Automated Clearinghouse Association ("NACHA") to my bank account indicated below at the depository financial institution named below (the "Depository"), and to credit the value of such ACH debit entries to the account I maintain at Exante Bank in connection with the HSA program. I understand that I may revoke this authorization by giving at least sixty (60) days written notice of cancellation to Exante Bank at the address listed on this form, and that the revocation will not apply to transactions initiated prior to the Bank's receipt of the notice, or to adjusting entries on previous transactions. I represent that I am the owner of the account named below and that I have the legal right to provide this authorization.

Depository Name

Branch

City/State/Zip

Routing Number

Account Number

Account Name (Please Print)

X _____
Signature of Account Holder Date

PLEASE ENCLOSE A "VOIDED" CHECK FROM THE ACCOUNT THAT IS TO BE DEBITED

I request the following initial and/or recurring debits to be made:

Transfer Amount \$ _____ Starting Date _____ Ending Date _____ Frequency: Weekly Monthly One Time

ACKNOWLEDGMENTS

By signing below, I acknowledge and agree to the following:

- This HSA is being opened in accordance with the provisions of Section 223 of the Internal Revenue Code. Notification of funding and distributions may be reported to the IRS.
- I assume complete responsibility for: (1) determining that I am eligible for an HSA each year that I make a contribution; (2) ensuring that all contributions I make are permitted under applicable tax laws; and (3) I am solely responsible for the tax consequences of any contributions (including rollover contributions) and distributions. I understand the eligibility requirements for the HSA deposits I make and I state that I qualify to make such deposits.
- I authorize the Bank to provide information about my HSA to my employer in connection with the establishment and maintenance of my HSA.
- The HSA is not an employee welfare benefit plan governed by the Employee Retirement Income Security Act (ERISA), even if it is offered through or contributed to by my employer.
- The HSA Card Agreement is applicable only if a card is issued on your account.
- I agree to the Schedule of Bank Fees which has been provided to me. I acknowledge that the Bank's fees are subject to change from time to time, provided that I understand that any Initial Account Setup and Monthly Maintenance Fees are non-refundable.
- I understand and agree that my monthly account statements will be made available to me electronically. I agree to notify Exante Bank in writing if I wish to have statements mailed to my home address.
- I agree that the custodian or trustee of my HSA is authorized to act without further inquiry in accordance with writings bearing my signature.
- The information I have provided above is true and complete.

X _____
Signature of Account Holder Date

Payment enclosed with application (if applicable): _____.

Mail application and opening deposit (if applicable) to: Exante Bank, P.O. Box 271629, Salt Lake City, UT 84127-1629

FOR BANK USE ONLY:

Account Funded by: Employer Employee Both

Contribution Type: Regular Transfer Rollover