Application & Beneficiary Designation Form

Please complete this Application & Beneficiary Designation Form and return to AxisPlus Benefits™ indicated on the back of this form.

ACCOUNT HOLDER INFORMATION *(*Required Fields)*

*FIRST NAME:	MI:	*LAST NAME:
*PREFERRED MAILING ADDRESS: ☐ HOME ADDRESS ☐ MAILING ADDRESS	*HOME ADDRESS:	

*CITY:	*STATE:	*ZIP:	*MAILING ADDRESS (If different from above):
*CITY:	*STATE:	*ZIP:	*HOME PHONE: / WORK PHONE:

EMAIL ADDRESS:	*DATE OF BIRTH:	*SOCIAL SECURITY NUMBER:
*MOTHER'S MAIDEN NAME (Security purposes only):	*CITY & STATE OF BIRTH:	

EMPLOYER INFORMATION

EMPLOYER NAME:

EMPLOYER ADDRESS:	CITY:	STATE:	ZIP:
IS YOUR HSA FUNDED THROUGH CAFETERIA PLAN DEDUCTIONS? ☐ YES ☐ NO			

ELIGIBILITY INFORMATION (You must check yes on each question to be eligible for an HSA)

☐ YES ☐ NO	I am currently, or will be upon the date of my first contribution, an eligible individual as described in the Custodial Account Agreement.
☐ YES ☐ NO	I understand that maintaining my eligibility is my responsibility and that the Custodian will assume that all contributions are made while I am eligible to do so.
☐ YES ☐ NO	I am currently, or will be upon the date of my first contribution, covered by a High Deductible Health Plan (HDHP) that meets the qualifications detailed in the Custodial Account Agreement.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) INFORMATION

HDHP CARRIER:	CHECK ONE: ☐ Single Coverage ☐ Family Coverage

PLAN EFFECTIVE DATE:	DEDUCTIBLE AMOUNT:	MONTHLY EMPLOYEE CONTRIBUTION AMOUNT*:

ADOPTION AGREEMENT

This application is for the establishment of my individually owned Health Saving Account at the Custodian displayed on the reverse side of this form. 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 Account Agreement, HSA Terms and Conditions Statement and the HSA Disclosure Statement. I also acknowledge that the Plan Service Provider (PSP) indicated on the reverse side of this form is authorized to perform transactions on my account and all such transactions initiated by the PSP should be treated as if initiated directly by me, the Account Holder.

I understand that I am responsible for all contributions made to my HSA. My Social Security may be reduced since Social Security taxes are not paid on my contributions. I authorize payroll reductions as contributions to my Health Savings Account as indicated above.

SIGNATURE OF ACCOUNT HOLDER:	DATE:

(Beneficiary Designation on next page)

(* For annual maximum information please see HSA Frequently Asked Questions Sheet available with AxisPlus Benefits™)

Application & Beneficiary Designation Form (cont.)

Pursuant to Section VI of the Custodial Account Agreement, you are authorized to designate one or more individuals as your Account Beneficiary(ies). For each designated person below, include their address, city, state, zip, social security number (if known) and relationship to you in the space provided. You must also designate a percentage of your remaining account (if any) to be distributed to that individual. **Note: All percentages must add up to 100%.**

PRIMARY BENEFICIARY(IES)

FIRST NAME:	MI:	LAST NAME:	%:
ADDRESS:		CITY:	
STATE:	ZIP:	SSN:	RELATIONSHIP:

FIRST NAME:	MI:	LAST NAME:	%:
ADDRESS:		CITY:	
STATE:	ZIP:	SSN:	RELATIONSHIP:

If all individuals listed as Primary Beneficiaries precede you in death or cannot be located after a reasonable search by the Custodian, all non-allocated funds (if any) in your account will be distributed to your Contingent Beneficiary(ies) designated below. In the event that no beneficiary can be located, your account balance (if any) will be distributed to your estate.

CONTINGENT BENEFICIARY(IES)

FIRST NAME:	MI:	LAST NAME:	%:
ADDRESS:		CITY:	
STATE:	ZIP:	SSN:	RELATIONSHIP:

FIRST NAME:	MI:	LAST NAME:	%:
ADDRESS:		CITY:	
STATE:	ZIP:	SSN:	RELATIONSHIP:

Note: Special rules apply in certain states if a married individual does not select his/her spouse as beneficiary. If you reside in a community or marital property state and designate a person other than your spouse as beneficiary, you must obtain authorization from your spouse. It is the responsibility of the Account Holder to ensure that the individual(s) designated as beneficiary(ies) are legally authorized to act in that fashion.

ELECTRONIC FUNDS TRANSFER

I hereby authorize my Plan Service Provider (PSP) to facilitate Electronic Funds Transfer (EFT) between my Health Savings Account (HSA) and my Personal Bank Account as indicated below. These EFT transactions will be facilitated by the PSP but will be initiated by the Custodian. EFT transactions will be either a withdrawal from my Personal Bank Account for subsequent deposit into my HSA or will be a withdrawal from my HSA for subsequent deposit into my Personal Bank Account.

ACCOUNT TYPE: ☐ Checking Account ☐ Savings Account	BANK NAME:	
ADDRESS:	CITY:	STATE:
ZIP:	BANK ROUTING NUMBER (First 9 numbers on bottom of check):	BANK ACCOUNT NUMBER (Second set of numbers):

DEBIT CARD PAYMENT METHOD

☐ I hereby request a AXISPlus® MasterCard® debit card as an alternate distribution method from my HSA account. I understand that additional fees may apply. (See Article IV of the Custodial Account Agreement for terms of usage.) Print exactly as you would like it to appear on your card. 21 characters maximum, including spaces.

NAME ON 1ST CARD: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

NAME ON 2ND CARD: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

CUSTODIAN	CUSTODIAL ACCOUNT MANAGER
National Advisors Trust 10881 Lowell Ave., Suite 100, Overland Park, KS 66210 Phone: (877) 527-3476 E-Mail: info@nationaladvisorstrust.com	DataPath Financial Services, Inc. P.O. Box 55068 • Little Rock, AR 72215 Web: www.myHSAtoday.com Email: info@myHSAtoday.com
PLAN SERVICE PROVIDER	**MARKETING REPRESENTATIVE**
AxisPlus Benefits™ 860 E. 9085 S. Sandy, UT 84094 Phone: (877) 872-2125 • Fax (801)878-0665 E-Mail: info@myaxisplus.com	NAME: SERIAL NUMBER (To be completed by the PSP):

OFFICE USE ONLY	
ACCOUNT NUMBER:	DATE:
NOTES:	SIGNATURE: