West Ohio United Methodist Credit Union
WOC Health Plan Participant
HSA Enrollment Packet

Enrollment Packet

1. Membership Application & Health Savings Account Custodial Agreement
2. HSA Agent Designation Request—*Optional*
3. Employer Authorization for Electronic Withdrawal of Funds—*Optional*
4. HSA Check Order Form—*Optional*

Disclosures and Other Information

1. Frequently Asked Questions
2. Procedures for Opening a New Account Disclosure
3. Privacy Policy Notice
4. Membership Agreement
5. Credit Union Fee Schedule

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Membership Application & Health Savings Account (HSA) Custodial Agreement

The account owner named below is establishing this Health Savings Account (HSA) exclusively for the purpose of paying or reimbursing qualified medical expenses of the account owner, his or her spouse, and dependents. The account owner represents that, unless this account is used solely to make rollover contributions, he or she is eligible to contribute to this HSA; specifically, that he or she: (1) is covered under a high deductible health plan (HDHP); (2) is not also covered by any other health plan that is not an HDHP (with certain exceptions for plans providing preventive care and limited types of permitted insurance and permitted coverage); (3) is not enrolled in Medicare; and (4) cannot be claimed as a dependent on another person's tax return.

Health Savings Account Member Application and Ownership Information

Member/Account Owner:	Member Account Number:
Street Address:	Social Security Number/TIN:
City, State & Zip:	Driver's License Number:
Home Phone:	State Issued/Verified By:
Work Phone:	Date of Birth:
Cell Phone:	Email Address:
Eligibility for Membership:	

Health Savings Account Services

☒ HSA Savings ($25 minimum balance required) ☐ HSA Checking ☐ Online Account Access ☐ Electronic Statements

☐ Debit Card ☐Secondary Debit Card (Name: ______________ Relationship: ______________ Date of Birth: ______________)

Health Savings Account Beneficiary Designation

Beneficiary Name	*Percentage	Relationship	Address	City, State & Zip
	%			
	%			
	%			

*Beneficiary percentage must total 100%

THE ACCOUNT OWNER AND THE CUSTODIAN (WEST OHIO UNITED METHODIST CREDIT UNION) MAKE THE FOLLOWING AGREEMENT:

Article I

1. The custodian will accept additional cash contributions for the tax year made by the account owner or on behalf of the account owner (by an employer, family member, or any other person). No contributions will be accepted by the custodian account owner that exceeds the maximum amount for family coverage plus the catch up contribution.
2. Contributions for any tax year may be made at any time before the deadline for filing the account owner's federal income tax return for that year (without extensions).
3. Rollover contributions from an HSA or an Archer Medical Savings Account (Archer MSA) (unless prohibited under this agreement) need not be in cash and are not subject to the maximum annual contribution limit set forth in Article II.
4. Qualified HSA distributions from a health flexible spending arrangement or health reimbursement arrangement must be completed in a trustee-to-trustee transfer and are not subject to the maximum annual contribution limit set forth in Article II.
5. Qualified HSA funding distributions from an individual retirement account must be completed in a trustee-to-trustee transfer and are not subject to the maximum annual contribution limit set forth in Article II.

Article II

1. For calendar year 2007, the maximum annual contribution limit for an account owner with single coverage is $2,850. This amount increases to $2,900 in 2008. For calendar year 2007, the maximum annual contribution limit for an account owner with family coverage is $5,650. This amount increases to $5,800 in 2008. These limits are subject to cost-of-living adjustments after 2008.
2. Contributions to Archer MSAs or other HSAs count toward the maximum annual contribution limit to this HSA.
3. For calendar year 2007, an additional $800 catch-up contribution may be made for an account owner who is at least 55 or older and not enrolled in Medicare. The catch-up contribution increases to $900 in 2008 and $1,000 in 2009 and later years.
4. Contributions in excess of the maximum annual contribution limit are subject to an excise tax. However, the catch-up contributions are not subject to an excise tax.

Article III

It is the responsibility of the account owner to determine whether contributions to this HSA have exceeded the maximum annual contribution limit described in

Article II. If contributions to this HSA exceed the maximum annual contribution limit, the account owner shall notify the custodian that there exist excess contributions to the HSA. It is the responsibility of the account owner to request the withdrawal of the excess contribution and any net income attributable to such excess contribution.

Article IV

The account owner's interest in the balance in this custodial account is nonforfeitable.

Article V

1. No part of the custodial funds in this account may be invested in life insurance contracts or in collectibles as defined in section 408(m).
2. The assets of this account may not be commingled with other property except in a common trust fund or common investment fund.
3. Neither the account owner nor the custodian will engage in any prohibited transaction with respect to this account (such as borrowing or pledging the account or engaging in any other prohibited transaction as defined in section 4975).

Article VI

1. Distributions of funds from this HSA may be made upon the direction of the account owner.
2. Distributions from this HSA that are used exclusively to pay or reimburse qualified medical expenses of the account owner, his or her spouse, or dependents are tax-free. However, distributions that are not used for qualified medical expenses are included in the account owner's gross income and are subject to an additional 10 percent tax on that amount. The additional 10 percent tax does not apply if the distribution is made after the account owner's death, disability, or reaching age 65.
3. The custodian is not required to determine whether the distribution is for the payment or reimbursement of qualified medical expenses. Only the account owner is responsible for substantiating that the distribution is for qualified medical expenses and must maintain records sufficient to show, if required, that the distribution is tax-free.

Article VII

If the account owner dies before the entire interest in the account is distributed, the entire account will be disposed of as follows:
1. If the beneficiary is the account owner's spouse, the HSA will become the spouse's HSA as of the date of death.
2. If the beneficiary is not the account owner's spouse, the HSA will cease to be a HSA as of the date of death. If the beneficiary is the account owner's estate, the fair market value of the account as of the date of death is taxable on the account owner's final return. For other beneficiaries, the fair market value of the account is taxable to that person in the tax year that includes such date.

Article VIII

1. The account owner agrees to provide the custodian with information necessary for the custodian to prepare any report or return required by the IRS.
2. The custodian agrees to prepare and submit any report or return as prescribed by the IRS.

Article IX

Notwithstanding any other article that may be added or incorporated in this agreement, the provisions of Articled I through VIII and this sentence are controlling. Any additional article in this agreement that is inconsistent with section 223 or IRS published guidance will be void.

Article X

This agreement will be amended from time to time to comply with the provisions of the Code or IRS published guidance. Other amendments may be made with the consent of the persons whose signatures appear below.

Form 5305-C (November 2007) Department of the Treasury Internal Revenue Service

Tax Identification Number Certification and Backup Withholding Information

Under penalties of perjury, I certify that: 1) The number shown on this form is my correct taxpayer identification number, 2) I am not subject to backup withholding because: a) I am exempt from backup withholding, or b) I have not been notified by the Internal Revenue Service (IRS) 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 and3) I am a U.S. person (including a U.S. resident alien).

CERTIFICATION INSTRUCTIONS: Cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividend on your tax return. Cross out item 3 and complete a W-8 BEN if you are not a U.S. person.

Authorization

By signing below, I agree to the terms and conditions of the Membership and Account Agreement, Truth-in-Savings Rate and Fee Schedule, Funds Availability Policy Disclosure, , if applicable, and to any amendment the Credit Union makes from time to time which are incorporated herein. I acknowledge receipt of a copy of the Agreement and Disclosure applicable to the accounts and services requested herein. If an access card or EFT service is requested and provided, I agree to the terms of and acknowledge receipt of the Electronic Funds Transfer Agreement. I further certify that the Credit Union has not given me tax or legal advice. Furthermore, I authorize the Credit Union to share my contact information with my health plan sponsor to assist them solely in the administration of my health plan benefits.

Account Owner's Signature ______________________________ Date: ____/____/2011

Custodian's Signature ______________________________ Date ____/____/2011

For Internal Use Only	Date of Membership	Account Opened By	Verified By:

West Ohio United Methodist Credit Union—P.O. Box 54843—Cincinnati, Ohio 45255—1-800-373-1059

www.umethodist.com

AGENT DESITNATION REQUEST
FOR HEALTH SAVINGS ACCOUNTS

OPTIONAL—COMPLETE THIS FORM ONLY IF YOU WISH TO NAME AN AUTHORIZED SIGNER (AGENT) FOR YOUR CREDIT UNION HSA SAVINGS AND/OR HSA CHECKING ACCOUNT WHO YOU GIVE PERMISSION TO HAVE FULL ACCESS TO YOUR HSA.

Member/Account Owner Information

Member/HSA Owner:	HSA Account Number:
Social Security Number:	Date of Birth:

Authorized Signer/Agent Designation & Information

I wish to designate an Agent on my HSA. This is a new designation, as I do not currently have an Agent on my HSA. (Please see item 34 in your Credit Union Membership Agreement for additional information on appointing an Agent to your account).

Name of Designated Agent:	Effective Date: January 1, 2012
Agent's Social Security Number:	Agent's Date of Birth:
Agency Designation: ☒ All accounts under this member account number ☐ Designate specific accounts: ____________________ ____________________	Home Address of Agent: ☐ Same as Member/HSA Owner ☐ Other ____________________ ____________________ ____________________
Agent's relationship to the Member/HSA Owner: ☐ Spouse ☐ Child ☐ Other (Please specify)________________	________________ ________ Agent's Driver's License Number: State Issued Please attach a copy of the Agent's driver's license or other state issued photo identification

I certify that the information provided by me on this form is accurate and may be relied upon by the Credit Union unless and until I provide written notification of revocation. I further certify that the Credit Union has not given me tax or legal advice. I understand that I am responsible for my decisions regarding this designation and will not hold the Credit Union responsible for any adverse consequences or penalties that may arise from this authorization.

X ________________________ ___/___/2011 X ________________________ ___/___/2011
Signature of Member/Account Owner Date Signature of Agent: Date

West Ohio United Methodist Credit Union—P.O. Box 54843—Cincinnati, Ohio 45254—1-800-373-1059
www.umethodist.com

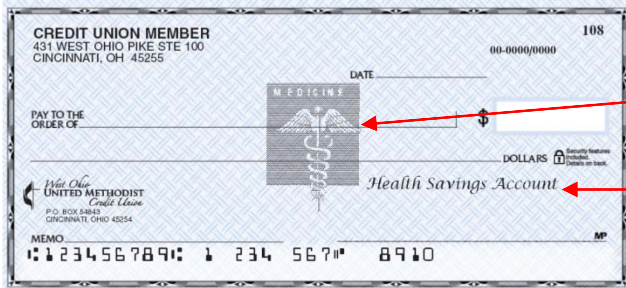
HSA Check Order Form

CHECK ORDERS ARE OPTIONAL

Design	Price	Number of Checks	Number of Deposit Slips
HSA Classic	$10.00	50	10

Please imprint my Health Savings Account (HSA) Checks as follows:

Name(s)	
Address	
City, State & Zip code	
Telephone # (optional)	(Leave blank if you do not want to include your telephone number on your checks)
Starting Check Number	1001



HSA check stock contains:

- Medical Symbol screened on the background of check
- OSL information: reads Health Savings Account

☐ Please ship my checks to the same address as listed above

☐ Mailing Address: ____

____

Please order 1 box and deduct all costs associated with this check order from my Credit Union Health Savings Checking Account.

X ______________________________ Date ____/____/2011

Account Owner's Signature

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