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

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HEALTH SAVINGS ACCOUNT
Application and Custodial Agreement

PERSONAL INFORMATION					
Name*				SSN*	
Physical Address*				DOB (mm/dd/yyyy)*	
City, State, Zip*				Marital Status	☐ Single ☐ 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					
☐ Yes ☐ No	Are you covered by an HSA qualified high deductible plan (HDHP)? (If you answer no, you are not eligible to establish an HSA.)			☐ Yes ☐ No	Are you covered by any other non-permitted health plan (i.e. Health FSA, spouse's non-HDHP medical plan)?
Carrier Name	Hometown Health			☐ Yes ☐ No	Are you covered by Medicare?
Effective date of HDHP	_____	Yearly Deductible	$_____	☐ Yes ☐ No	Are you claimed as a dependent on another person's tax return?
Type of Coverage	☐ Individual ☐ 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*	Washoe County	Contact	Lisa M. Daniels
Address	1001 E. Ninth Street	Telephone Number	(775) 328-2082
City, St, Zip	Reno, NV 89512	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)	
Employer	$_____	$_____	☐ Monthly ☐ Bi-monthly ☐ Weekly ☐ Bi-weekly	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.
Individual	$_____	$_____		
Catch-up Contribution	$_____	$_____		

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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? ☐ Yes ☐ 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		☐	Primary
Address		DOB		☐	Contingent
City, St, Zip		SSN		____%	Percent
Name		Relationship		☐	Primary
Address		DOB		☐	Contingent
City, St, Zip		SSN		____%	Percent
Name		Relationship		☐	Primary
Address		DOB		☐	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):

☐ 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.

☐ 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