Lake Shore Savings
Putting People First.™

HSA CUSTOMER ID VERIFICATION

PLEASE COMPLETE EACH LINE

NAME: _____

MAILING ADDRESS: _____

PHONE NUMBER: ( ) _____

EMAIL ADDRESS: _____

EMPLOYER & OCCUPATION: _____

DATE OF BIRTH: _____ **SOCIAL SECURITY #:** _____

LICENSE/STATE ID #: _____ **STATE OF ISSUANCE:** _____

ISSUE DATE: _____ **EXPIRATION DATE:** _____

MARITAL STATUS: **SINGLE** _____ **MARRIED** _____

PLAN TYPE: **INDIVIDUAL** _____ **FAMILY** _____

****BENEFICIARY****

NAME: _____

RELATIONSHIP: _____

ADDRESS: _____

_____

PHONE NUMBER: ( ) _____

SOCIAL SECURITY #: _____

DATE OF BIRTH: _____

VERIFIED BY: (Signature of HSA Owner) _____

SPOUSAL CONSENT

HSA owners who reside in or whose HSA is located in a community or marital property state should review this section.

This section may have important tax consequences to you and your spouse. It is your responsibility to determine whether spousal consent is necessary and therefore you should seek the guidance of a tax or legal professional prior to completing.

☐ I Am Not Married – I understand that if I become married in the future, I must complete a new beneficiary designation form that includes the spousal consent provisions.

☐ I Am Married – I understand that if I designate a primary beneficiary other than my spouse, my spouse must sign below.

Consent of Spouse. By signing below, I acknowledge that I am the spouse of the HSA owner and agree with and consent to my spouse's designation of a primary beneficiary other than, or in addition to, me. I understand that with my consent I transfer my community property interest in this HSA to my spouse as his or her separate property. I have been advised to consult a competent advisor and I assume all responsibility regarding this consent. The Trustee/Custodian has not provided me any legal or tax advice.

Signature of Spouse X _____ Date

Witness X _____ Date

AUTHORIZED SIGNER

To permit someone else (such as your spouse) to authorize payments from your HSA (e.g., to write checks or use a debit card, if applicable), complete the information below and have the person designated as the Authorized Signer sign the "Acknowledgment" section at bottom. When Nondurable is checked, the authority of the Authorized Signer ends at your incapacity or disability.

☐ Durable ☐ Nondurable

Name: **Relationship:**

Date of Birth: **Tax ID Number:**

Address:

HSA AUTHORIZED SIGNER ACKNOWLEDGMENT AND AGREEMENT:

Account Owner Statement: By signing below, you acknowledge and agree that you understand the statements above and have designated the named individual as Authorized Signer on this HSA.

Signature of HSA Owner X _____ Date

Authorized Signer Statement: As an Authorized Signer, you understand that you are not the account owner. You agree to immediately notify this financial institution in writing of the account owner's death. You acknowledge and agree that you shall not use this account after the owner's death.

Signature of Authorized Signer X _____ Date

ACKNOWLEDGMENT

By signing this *HSA Application*, I certify that the information I have provided is true, correct, and complete, and the Trustee/Custodian may rely on what I have provided. In addition, I have read and received copies of this HSA Application, the applicable IRS Form 5305, and the Disclosure Statement, including the applicable fee schedule, for this HSA. I agree to be bound to their terms and conditions.
I understand that the Trustee/Custodian has no duty or responsibility to determine whether my HDHP complies with the requirements of Section 223 of the Internal Revenue Code nor to determine or validate whether distributions I take from my HSA are used to pay for qualifying medical expenses. I assume all responsibilities for the HSA transactions I conduct, and I will indemnify and hold the Trustee/Custodian harmless from any consequences related to executing my directions. If I have indicated any amounts as prior year contributions, I understand the contributions will be credited for the prior tax year. I have been advised to seek competent legal and tax advice and have not been provided any such advice from the Trustee/Custodian.

Signature Of HSA Owner X _____ Date

Signature Of Authorized Signer X _____ Date

Signature of HSA Trustee/ Custodian Representative X _____ Date

ACCOUNT/PLAN #:

DEFINITIONS. The terms "I", "we", "me", and "my" refer to the IRA/ESA/HSA Account Owner and any authorized individual identified on this document for the plan.

CHECKS AND DEBIT CARD ISSUANCE. (HSA accounts only) I understand that I may receive checks and/or a debit card for my Health Savings Account (HSA), and that these payment tools are intended to be used by me, the HSA owner, and any authorized signer (optional) on the HSA to pay for qualifying medical expenses. I am also responsible for understanding the distribution rules and that such amounts will be reported to the Internal Revenue Service as "normal" distributions at the end of the year. I am aware that I should not use the checks or debit card for any payments that are not qualified medical expenses. I understand any distributions taken or used incorrectly may be subject to taxes and penalties, and I assume full responsibility for my actions.

ADDITIONAL TERMS

HSA AUTHORIZED SIGNER ACKNOWLEDGMENT AND AGREEMENT:

Account Owner Statement: By signing below, you acknowledge and agree that you understand the statements above and have designated the named individual as Authorized Signer on this HSA.

Signature of HSA Owner

X_____

Date

Authorized Signer Statement: As an Authorized Signer, you understand that you are not the account owner. You agree to immediately notify this financial institution in writing of the account owner's death. You acknowledge and agree that you shall not use this account after the owner's death.

Signature of Authorized Signer

X_____

Date

ACKNOWLEDGMENT

By signing this document, I acknowledge that I have opened the type of account designated above. My signature acknowledges the receipt of the IRA/ESA/HSA Account Agreement and I agreed to be bound by the IRA/ESA/HSA Account Agreement. I acknowledge receipt of a copy of this institution's Privacy Policy, if one was not previously provided to me. I also acknowledge receipt, when applicable, of this institution's Truth In Savings, Funds Availability Policy, Electronic Fund Transfer, and/or the Substitute Check Policy Disclosure. I authorize this institution, in its sole discretion, to make inquires from any consumer reporting agency, including a check protection service, in connection with this account.

Signature of Account Owner:

X_____

Date

Signature of HSA Authorized Signer/ESA Responsible Individual:

X_____

Date

Signature of ESA Depositor:

X_____

Date

TAXPAYER IDENTIFICATION NUMBER CERTIFICATION

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me, and
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 (*NOTICE: If you are subject to backup withholding, cross out this line*), and
3. I am a U.S. citizen or other U.S. person.

X_____

SIGNATURE

Date

Taxpayer Identification Number:

FOR INSTITUTION USE

Lake Shore Savings Bank ATM/Debit Card Application

Employee requesting card _____ Branch #_____ Date_____

Customer Name _____

Social Security Number _____

Address _____

City, State, Zip Code _____

Type of Card Requested

☐ 572872 ATM Card Checking/Statement Savings Account number _____

☐ 540317 Debit Card Checking Account Number _____

☒ 519492 HSA Card HSA Account Number _____

☐ New Order ☐ Reorder (reason) _____ ☐ Replacement Fee Collected at Branch

(*Debit and HSA card PIN can be selected at the time of card activation through the IVR system 1-800-992-3808*)

PIN requested for **ATM Cards only** _____

I have reviewed the ATM/DEBIT card application and agree that the above information is correct:

X _____

Customer Signature (Required to process the order)

Customer Overdraft Services for Debit Card ☐ Opt in ☐ Opt Out
(Overdraft Services Consent Form must be completed or on file)

Comments or other mailing instructions:

_____

INSTANT ISSUE ONLY:

☐ Card has been issued at branch. Employee Initials _____

Card Number: _____

HEALTH SAVINGS ACCOUNT (HSA) ACCOUNT INFORMATION

Complete entire form except the account number field.

LAST NAME

FIRST NAME

PHONE NUMBER

			-				-				

BANK NAME

L	A	K	E		S	H	O	R	E		S	A	V	I	N	G	S		

ROUTING NUMBER

2	2	2	3	7	1	6	5	6											

ACCOUNT NUMBER

ADDITIONAL AMOUNT DEPOSITED PER PAY $_____

ACCOUNT MAINTENANCE REQUESTED:
(select one)

	NEW ACCOUNT REQUEST
	UPDATE DEPOSIT REQUEST
	CANCEL DEPOSIT REQUEST

SIGNATURE: _____

DATE: _____

Please return form to Human Resources with a copy of back and front of your state issued ID.
Send via fax to 716-485-4679, via email @ HR@resourcecenter.org, or via text to 716-637-8295.