First MSA, Inc.

Health Savings Account Application

FIRST MSA, INC.
1044 MacArthur Road, Reading, Pa. 19605
(Ph) 610-678-6000 or (888) 769-8696 (Fax) 610-678-6818
Website: www.FirstMSA.com

Bank Use Only

Checking Acct # 5 6 ___ ___ ___ ___ ___ ___ ___

Application and Agreement

Name		Soc. Sec. #		Date of Birth
Address	City		State	Zip Code
Home Phone	Business Phone		Driver's License #	

Type of initial Deposit: ☐ Current Year Amount $_________ ☐ Prior Year Amount $_________ ☐ Transfer Amount $_______ ☐ Rollover Amount $________

Check One: Self-employed contributing with a personal check should choose Employee Contributions; Self-employed contributing with a business check should choose Employer Contributions.

_______ **Employee Only Contributions**

_______ **Employer Only Contributions** (Complete company information below)

_______ **Both Employer and Employee are contributing to HSA** (Complete company information below)

Company Name		Tax ID #	
Address	City	State	Zip Code
Contact Person	Phone Number		

Designation of Beneficiary(ies): I hereby certify that if I die before distribution has been completed the value of my Health Savings Account shall be distributed to the Beneficiary(ies) named below.

Primary Name		Address		City, State, Zip Code
Percent	Soc. Sec. #	Relationship		Date of Birth
Primary Name		Address		City, State, Zip Code
Percent	Soc. Sec. #	Relationship		Date of Birth
Contingent Name		Address		City, State, Zip Code
Percent	Soc. Sec. #	Relationship		Date of Birth
Contingent Name		Address		City, State, Zip Code
Percent	Soc. Sec. #	Relationship		Date of Birth

Optional: I hereby designate the following individual(s) as additional authorized signor(s) on my Health Savings Account to sign checks.

Authorized Signor Printed Name	Signature
Authorized Signor Printed Name	Signature

☐ Yes, I would like to make Direct Deposits made to my Health Savings Account. If "Yes" Please include a voided check from the account you wish to withdraw from.

Direct Deposit Amount $___________ Day of Month _________

Health Plan Information: _____ Individual Health Plan _____ Family Health Plan	
Health Insurance Company:	
Annual Deductible $	**Effective Date**
Maximum yearly contribution for individuals is 100% of the annual deductible, not to exceed $2600. Maximum yearly contribution for a family is 100% of the annual deductible, not to exceed $5150. **Note:** Maximum HSA contributions are based on a full calender year. Therefore, in the first year, the amount of the contribution is pro-rated on a 1/12th basis depending on the effective date or the insurance plan.	
Payment Option: Check one: _____ Automatic monthly $7.00 debit _____ $84.00 Annual Payment	
Please remit with application: Make one check payable to "First MSA, Inc." This check should include any current year or prior year(if applicable) contributions, and also the $25.00 one-time setup fee. **When choosing the Annual Payment Option**, the first year is pro-rated for only those months remaining in the current year. Total the number of months remaining in the year and multiply by $7.00. Include this amount with your remittance.	
Send Application and Remittance to: First MSA, Inc., 1044 MacArthur Road, Reading Pa. 19605 Note: A minimum opening contribution of $50.00 is required	

BACKUP WITHHOLDING CERTIFICATE:

By signing below you certify under penalties of perjury:

1. The number shown on this form is my correct taxpayer identification number
2. I am not subject to backup withholding either because I have not been notified that I am subject to backup withholding as a result of failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding. The Internal Revenue Service does not require your consent to any provisions of this document other than the certification required to avoid backup withholding.

Instructions

You can name one or more persons to be the primary and contingent beneficiaries of your account, including your estate or a trust. Please provide complete information about each beneficiary. If the beneficiary is a trust, please provide the names of the trustees, the date of the trust and the trust's tax ID number. If you designate more than one primary or contingent beneficiary, please be sure that you indicate the percentage share each is to receive and that the percentages add up to 100%.

Any balance left in your account at your death will be paid to the primary beneficiaries in accordance with the share percentages you designate. If the primary beneficiary should predecease you and there are primary beneficiaries who are still living, the deceased beneficiary's share will be distributed to the remaining primary beneficiaries, in proportion to their payment percentage. If no primary beneficiary is living at the time of your death, the balance will be distributed to your contingent beneficiary. If no primary or contingent beneficiary survives you, the balance will be paid to your surviving spouse. If you are not survived by a spouse, we will pay the balance to your estate. If no percentages are indicated for primary or contingent beneficiaries, equal percentages will be assumed.

As disclosed in the HSA Disclosure Statement, your surviving spouse can continue his or her interest in your HSA as his or her own HSA at your death only if he or she is named beneficiary under your HSA. This is the case even if your surviving spouse ultimately obtains a right to assets under your HSA (e.g., your surviving spouse is the sole beneficiary of your estate). If any person other than your spouse is a named beneficiary, or any person (including your surviving spouse) otherwise acquires your interest in your HSA on account of death, the HSA portion of the HSA with respect to which there is a non-spouse beneficiary will cease to be a health savings account as of the date of your death.

Health Savings Account Adoption Agreement:

This agreement when signed by me and accepted by First MSA, Inc. acting as an agent for Leesport Bank, as Custodian, incorporates the Leesport Bank Health Savings Account Custodial Agreement (the "HSA Agreement"). By signing this Agreement, I acknowledge:

1). That there are fees for the First MSA, Health Savings Account.
2). That I must be covered by a HSA-qualify "high deductible" health plan to be eligible to make HSA contributions (other than roll-over contributions) or have HSA contributions made by my employer.
3). That my HSA has been established for the purpose of paying qualified medical expenses, and if distributions are not used for this purpose, I may be subject to ordinary income and penalty taxes, which I must report to the IRS.
4). That no loans may be taken from my HSA and no portion of my HSA may be used as security or collateral for a loan.
5). That I am responsible for reporting my HSA and that First MSA, Inc. has no duty to determine the investment, tax or other consequences resulting from my actions involving my HSA.
6). That First MSA, Inc. is not an insurance company who offers the high deductible insurance plans.
7). That I will receive a copy of the First MSA Disclosure Statement and Sub-Account Agreement in my "Welcome Kit".
8). I understand that First MSA, Inc. is acting as an agent for Leesport Bank (Member FDIC).
9). I understand I have a 10-day grace period to close my account and receive a full refund. However, after 10 days any fees or charges will be non-refundable.

Sign Here X____ ______________________________

Signature of Primary Account Holder **Date**