MAGNACARE℠

HSA - Enrollment Form

Instructions: Use this form to change an existing/already established Health Savings Account (HSA). Complete this form and mail it to: MagnaCare, LLC, PO BOX 161390, Altamonte Springs, FL 32714. For assistance, call 844.621.5990 or send an email to: service@magnacare.com

Instructions: Complete all fields below.

Name: First _____ Last_____ Middle Initial _____

Street Address: Street _____
If P.O. Box – also provide street
City _____ State_____ Zip_____

Mailing Address: Street _____
If different
City _____ State_____ Zip_____

Date of Birth: (mm/dd/yyyy) _____ Social Security Number ____-____-_____ Married ☐ (or) Single ☐

Contact Info: Phone _____ E-Mail _____

Additional Info: License Number_____ Issue State_____ Expiration Date (mm/dd/yyyy) _____

If you do not have a license then provide alternative

State ID Number_____ Issue State_____

Passport Number_____ Country _____

Military/Govt. ID Number_____

Other ID Number_____

Are you subject to backup withholding? Yes ☐ No ☐

Would you like to order checks? Yes ☐ No ☐

Contribution Election: Per Pay Period $_____

Effective Date of Contributions: (mm/dd/yyyy) _____

Employer: Name_____ City_____ State _____

Authorized Signer – Optional

If you wish to designate an authorized signer on your account, please complete all of the required fields below. If you are unable to provide all of the required information on your authorized signer, they will not be added to your account. You hereby designate the following individual as an authorized signer on your Health Savings Account (HSA). By designating an authorized signer on your account, you authorize the person designated above as "Authorized Signer" to transact business with and give instructions to Avidia Bank regarding your HSA; make deposits or withdrawals by any means acceptable to Avidia Bank, including paper and electronic methods such as ACH and Internet-generated transactions; receive and have access to account information, including balances and transactions; endorse any instruments such as checks, orders or other documents for the payment of funds; and to otherwise serve as agent for your Avidia Bank HSA. You specifically authorize Avidia Bank, as custodian of your HSA, to rely upon this authorization and designation until such time, if any, that Avidia Bank receives a written revocation of this authorization, and has had a reasonable time to act upon the revocation. You understand that you are responsible for ensuring that your authorized signer reads and understands the Avidia Bank Account Documents which have been provided to you. You hold harmless and indemnify Avidia Bank against any claims against or losses Avidia Bank may suffer arising out of Avidia Bank's reliance on this authorization, and release Avidia Bank from any liability arising from such reliance, unless otherwise prohibited by law. You understand that you bear sole responsibility for any tax consequences that result from any actions taken by the authorized signer regarding your account. NO PRESENT OR FUTURE OWNERSHIP OR RIGHT OF SURVIVORSHIP IS GIVEN TO THE AUTHORIZED SIGNER BY THIS AUTHORIZATION. UPON NOTICE TO AVIDIA BANK OF YOUR DEATH, THIS AUTHORIZATION TERMINATES, AND RIGHTS TO FUNDS IN YOUR ACCOUNT WILL BE TRANSFERRED TO YOUR BENEFICIARIES. IF YOU DID NOT NAME A BENEFICIARY, YOUR ACCOUNT BALANCE WILL ONLY BE PAYABLE TO YOUR ESTATE.

Name: First _____ Last_____ Middle Initial _____

Street Address: Street _____
If P.O. Box – also provide street
City _____ State_____ Zip_____

Relationship: _____ Date of Birth (mm/dd/yyyy) _____ Social Security Number _____-_____-_____

Contact: Phone Number_____

Beneficiary Designation – Optional Account Selections

By completing the information below, you agree as follows: At the time of my death, the Primary Beneficiary(ies) named below will receive the funds remaining in my HSA. If all of my primary beneficiaries die before me, the Secondary Beneficiary(ies) named below will receive the funds in my HSA. If a beneficiary dies before me, such beneficiary's share will be reallocated on a pro-rated basis to the other beneficiaries within the same class. If all of the beneficiaries die before me, my HSA funds will be paid to my estate. If no percentages are assigned to beneficiaries, the beneficiaries within such class will share equally. If the percentage total for each beneficiary classification does not equal 100 percent, any remaining percentage will be divided equally among the beneficiaries within such class. If my spouse received the HSA as a result of being named as beneficiary, my spouse may choose to continue the HSA in his or her name by providing a written election to the Custodian and by signing the forms and providing the information the Custodian requires. For any non-spouse beneficiary, the HSA terminates as of my date of death and becomes payable. I understand that in certain states, my spouse's consent may be necessary if I wish to name a person other than, or in addition to, my spouse as a beneficiary and that I should consult with an attorney before making such a beneficiary designation. I acknowledge that the Custodian has no obligation to determine whether my beneficiary designation(s) comply with applicable law. I hereby indemnify and hold the Custodian harmless from and against any and all claims, damages, liabilities and costs (including attorney's fees) arising as a result of the Custodian's payment of my HSA in accordance with the foregoing Beneficiary Designation. I intend that the foregoing indemnity will be binding upon myself, my heirs and my estate.

Primary Beneficiaries:

Name	Relationship	Social Security No.	Date of Birth (mm/dd/yyyy)	Address	% (must total 100)

Secondary Beneficiaries:

Name	Relationship	Social Security No.	Date of Birth (mm/dd/yyyy)	Address	% (must total 100)

By singing below I certify that:

- I am, or will be covered by a qualified High Deductible Health Plan (HDHP), I am not enrolled in Medicare or covered under other health insurance that is not compatible with an HSA, and I may not be claimed as a dependant on another person's tax return (excluding spouses per the IRS).
- Avidia Bank is hereby appointed to serve as custodian of my Health Savings Account.
- I have reviewed and agree to the following Agreements and Disclosures; Deposit Account Agreement, Health Savings Custodial, Funds Availability, Electronic Funds Transfer, Check 21. Truth in Savings and Privacy Statement.
- Within seven (7) calendar days from the date I open this HSA, I may revoke authorization for opening the account by mailing a written notice to Avidia Bank, PO BOX 370, Hudson MA 01749.
- To help the government fight the funding of terrorism and money laundering activities, Federal Law requires that all financial institutions obtain, verify and record information that identifies each person who opens an account. What this means to you: when you open an account we will need you and your authorized signer to provide name, street address, date of birth and other information that will allow us to identify you and your authorized signer. We may also ask to see your driver's license or other identifying documents.
- I understand account statements are delivered electronically and I can change delivery preference once enrolled for online access.
- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me).
- 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.
- I am a U.S. citizen or other U.S. person.

Print Name _____Signature _____ Date _____