

Administered By:

First Horizon Health Savings Account (HSA) Enrollment Form and Agreements



Please provide the information below to open your Health Savings Account ("HSA") with First Horizon Bank, a division of First Tennessee Bank National Association, the custodian of your HSA. This information will be shared with First Horizon Msaver, Inc., along with other information as indicated in this Application, to assist First Horizon Msaver in providing HSA administrative services to you. Medical Mutual of Ohio and Consumers Life Insurance Company are not affiliated with First Horizon Bank, or its affiliates.

PERSONAL INFORMATION

Title: [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Dr. Name: (First) \_\_\_\_\_ (M) \_\_\_\_\_ (Last) \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address (if different from above) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone Number \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_ Email Address \_\_\_\_\_

Are you a US Citizen? [ ] Yes [ ] No Are you a citizen of any other country? [ ] Yes [ ] No If yes, which? \_\_\_\_\_

USA PATRIOT ACT INFORMATION (required)

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 to you: When you open an account we will ask for your name, street address, date of birth and other information that will allow us to identify you.

Form of Identification: [ ] Drivers License [ ] State ID [ ] Passport [ ] Military ID ID# \_\_\_\_\_

Issuing State/Branch/Country \_\_\_\_\_ Date of Issuance \_\_\_\_\_ [ ] None Expiration Date \_\_\_\_\_ [ ] None

ADDITIONAL AUTHORIZED SIGNERS (OPTIONAL)

Regulations require that only one individual own an HSA. An account holder may want a spouse, or another third party, to have access to funds within the HSA by naming them as an additional authorized signer. I (account holder) designate the following individual(s) as additional authorized signer(s) on my Health Savings Account. I understand these individuals will receive a Visa® debit card for use on this account.

First Additional Signer

Name (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_

Second Additional Signer

Name (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_

BENEFICIARY DESIGNATION

Primary Beneficiary (ies)

Table with 6 columns: Name, Relationship, Social Security #, Date of Birth, Address, % (Must total 100)

Secondary Beneficiary (ies)

Table with 6 columns: Name, Relationship, Social Security #, Date of Birth, Address, % (Must total 100)

At the time of my death, the primary beneficiary(ies) named above will receive the funds remaining in my HSA. If all of my primary beneficiaries die before me, the secondary beneficiary(ies) named above will receive the funds in my HSA. If a beneficiary dies before me, such beneficiary's share will be reallocated on a pro-rata 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.

## INITIAL HSA CONTRIBUTION

**Minimum Initial Contribution is \$100.00**  
**(Make check payable to First Horizon Bank).**

**Check One:**  Initial Contribution is Included (Complete all information below)  
 My Initial contribution will be made by my Employer at a later time

Initial HSA Contribution \$ \_\_\_\_\_ (For Tax Year 20\_\_\_\_)      Initial deposit made by Employer \$ \_\_\_\_\_ Individual \$ \_\_\_\_\_

Is this a rollover?  Yes  No

In case of a rollover, you certify that this contribution is a rollover contribution within the meaning of Internal Revenue Code Section 223, that the rollover is being made within 60 days of receipt, and you have not received a rollover in the last 12 months.

Amount of rollover contribution \$ \_\_\_\_\_

## FUTURE CONTRIBUTIONS - ACH AUTHORIZATION

**(Not Applicable if you contribute to your HSA through your employer's payroll deduction program.)**

If you elect to make recurring direct contributions to your HSA from your account at another financial institution, please complete this section. By doing so, you authorize First Horizon Bank to initiate debit entries from your checking/savings account(s) at the financial institution listed below, and if necessary, debit or credit entries for adjustments due to error. This authorization is to remain in full force and effect until First Horizon Bank receives written notification from you in such time and in such manner as to afford First Horizon Bank a reasonable opportunity to act on it. You acknowledge that you are the owner on the account entered in this form.

**ACCOUNT TO DEBIT** To make changes to your ACH contributions contact Customer Service at **1-866-889-8584**

Financial Institution Name: \_\_\_\_\_

Financial Institution Address: \_\_\_\_\_

Financial Institution City, State, Zip: \_\_\_\_\_

Routing Number (9 digits): \_\_\_\_\_ Account Number: \_\_\_\_\_

## TRANSACTION AMOUNT AND DATE

Start After Date: \_\_\_\_\_ Amount of Transfer: \$ \_\_\_\_\_

Weekly:  Monday  Tuesday  Wednesday  Thursday  Friday

Bi-Weekly:  Monday  Tuesday  Wednesday  Thursday  Friday

Monthly Date of the Month: \_\_\_\_\_

**ATTACH CHECK HERE**

## BANKING ONLINE

I am interested in enrolling in Banking Online and Bill Pay Online.

Do you want to receive your monthly account statements online?  Yes  No

You will be contacted via email within 3 to 5 business days with registration information.

## INVESTMENT INFORMATION

Yes, I'm interested in receiving information about the self-directed brokerage options that are available with my HSA.

Yes, I'm interested in receiving information about mutual fund options that are available with my HSA.

## Yes, I want to open a Health Savings Account with First Horizon Bank!

By signing below, I apply to open a Health Savings Account ("HSA") and certify that the information provided in this Enrollment Form is correct. I understand that First Horizon Bank, a division of First Tennessee Bank National Association, will be the Custodian for my HSA. I understand that you will send me the HSA Custodial Agreement, Depositors Agreement, Fee Schedule and any disclosures after my account is opened and that I will have seven (7) days from my receipt of those documents to revoke my account without penalty. I agree to be bound by all of the terms and conditions as described in the Enrollment Form ("Customer Agreement"), Depositors Agreement, the Custodial Agreement, and the Fee Schedule, as they may be amended by First Horizon Bank from time to time, unless I revoke my account within the time frame set forth above. Further, I understand that my Application is subject to acceptance by First Horizon Bank. I understand that the Visa® Debit Card is subject to the terms and conditions that are sent with the Card. I agree to pay all fees applicable to my HSA and authorize First Horizon Bank to deduct such fees from my HSA account. If I have completed the Beneficiary Designation section of this form, I direct that all funds remaining in any HSA at my death be paid to the Beneficiary(ies) as I have designated in that section of this form or in a new Beneficiary Designation that I may file prior to my death with the Custodian. This is a single ownership account in the name of the person identified in this Enrollment Form, and only that person can designate or change beneficiaries on this account. I acknowledge and agree that First Horizon Bank is solely responsible for providing Custodial account services. I acknowledge and agree that First Horizon Msaver, Inc. and its affiliates, may provide information to a referring third party concerning the products and services. First Horizon Bank is authorized to recognize my signature as set forth below, or the signature of any other person named in the Authorized Signers section of this Enrollment Form, in the payment of checks or the transaction of any other business on this Account, any one (1) such signature or other authority being necessary.



## Administrative Services Agreement

Please provide the additional information below to First Horizon Msaver for use in providing you administrative services for your First Horizon HSA. These administrative services include enrollment assistance and documents which may be provided through marketing representatives, access to a toll-free tax assistance help-line to answer any questions concerning HSAs, tax-related matters, qualified medical expenses, or other distributions. By submitting this First Horizon HSA Enrollment and Agreements, I acknowledge and understand that the administrative services provided by First Horizon Msaver, Inc. are separate and apart from the custodial services provided by First Horizon Bank. I further acknowledge and agree that First Horizon Msaver, Inc. and its affiliates, may provide information to a referring third party concerning the products and services I have obtained. If I have enrolled in this HSA program through my employer or if funding for my HSA is provided through my employer, I authorize First Horizon Msaver, Inc. or its affiliates to provide information concerning my First Horizon HSA, including the account number, to my employer. I acknowledge that neither First Horizon Bank nor First Horizon Msaver, Inc. has provided investment advice and that all investment decisions and instructions regarding my HSA will be made solely by me upon consultation with my personal broker or investment advisor. I understand that the monthly administrative fee described in the First Horizon Bank Fee Schedule will be paid to First Horizon Msaver, Inc. in consideration of the administrative services it provides to my First Horizon HSA. Medical Mutual of Ohio and Consumers Life Insurance Company are not affiliated with First Horizon Bank, or its affiliates.

### WELCOME KIT

Your HSA Welcome Kit, including the HSA Custodial Agreement, Depositor's Agreement, Fee Schedule and other important disclosures, will be mailed to you in a CD-disk format. If you prefer to receive your Welcome Kit in paper format, check here

### EMPLOYER INFORMATION

Company Name \_\_\_\_\_ Human Resources Contact \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Company Phone Number \_\_\_\_\_ Your Occupation \_\_\_\_\_

### HIGH DEDUCTIBLE HEALTH INSURANCE PLAN INFORMATION

Carrier Name **MMO/CLIC** Deductible Amount \$ \_\_\_\_\_  Individual  Family  
Agent Name \_\_\_\_\_ Agent Phone Number \_\_\_\_\_  
Effective date of your coverage by a qualified, high-deductible health plan \_\_\_\_/\_\_\_\_/\_\_\_\_

Agent ID # \_\_\_\_\_

**PARTICIPANTS IN AN HSA CANNOT BE COVERED BY ANOTHER HEALTH PLAN EXCEPT "PERMITTED" INSURANCE PRODUCTS.**

### HSA MONTHLY ADMINISTRATION FEE

The monthly administration fee of \$2.50 will be paid by Medical Mutual of Ohio. If you lose or terminate your Medical Mutual/CLIC HDHP coverage the monthly fee of \$2.50 will be automatically debited from your account.

### SIGNATURE AND ACKNOWLEDGEMENT

Under penalties of perjury, I certify that (1) the Taxpayer Identification Number (TIN) set forth in the Personal Information section above is my correct TIN (interest paid, if any, will be reported under this number), and that (2) I am exempt from backup withholding, or I am not subject to backup withholding as a result of a failure to report all interest or dividends, or the Internal Revenue Service has notified me that you are subject to backup withholding because of underreporting of interest or dividends on your tax return. Note: The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

I acknowledge that First Tennessee Bank National Association and its banking divisions, First Horizon Bank and Peoples Bank, are the same FDIC-insured institution and deposits held under each trade name are not separately insured, but are combined to determine whether a depositor has exceeded the \$100,000 federal deposit insurance limit.

**I have read and agreed to the terms of the First Horizon Bank Customer Agreement and the First Horizon Msaver Administrative Services Agreement. Facsimile signatures shall be deemed to be original signatures for purposes of this Enrollment Form and Agreements.**

X \_\_\_\_\_  
Customer Signature Date

### MAILING INSTRUCTIONS

For Enrollment Questions: Call 1-866-889-8584

Please mail your completed application to **First Horizon Msaver, P.O. Box 26106, Shawnee Mission, KS 66225.**  
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