National City® Health Savings Account (HSA)
Enrollment Instructions

Thank you for choosing National City to be your HSA provider. Enclosed in this package is everything you need to open your account. Should you have questions about your enrollment, please call 1-866-966-4729.

For additional information about the National City HSA program, please visit our website at **nationalcity.com/medmutualhsa.** For your convenience, this form can be downloaded from this site and completed electronically.

Use this checklist to help guide you through your enrollment:

- ☐ Verify your **eligibility** to open an HSA. You must meet these requirements*:
  - ☐ You are enrolled in a Qualified High-Deductible Health Plan (HDHP) and are not covered by health insurance that is not a Qualified HDHP
  - ☐ You are not enrolled in Medicare
  - ☐ You cannot be claimed as a dependent on another taxpayer's return

- ☐ **HSA Application**: *Complete and sign*
  - ☐ Complete applicant information
  - ☐ Indicate how you want to access your account
  - ☐ Designate a Beneficiary

- ☐ **Custodial Agreement**: Sign

- ☐ **HSA Signature Card**: *Complete and sign*
  - ☐ Enter Social Security Number in the "TIN" box
  - ☐ Sign and date as indicated

- ☐ **HSA Contribution Form** (Group Enrollees only, if required by your employer): Retain this form. Upon receipt of your welcome kit, complete and sign the form and submit it to your human resources officer, or as otherwise directed by your employer.

- ☐ **Submit** the completed enrollment package. Do not return this form to a National City branch. Mail to:

National City Direct Banking
Attn: HSA
4661 East Main St
Columbus Oh 43213

DO NOT SEND AN INITIAL CONTRIBUTION WITH YOUR ENROLLMENT PACKAGE.
Upon confirmation that your account has been opened AND after the effective date of your HDHP, you can make contributions at any National City branch, ATM, or, if applicable, electronically as facilitated by your employer.

What happens next?

Upon approval of your application, you will be contacted by a National City representative and will receive the following:

- Terms and conditions for your account
- HSA Contribution Authorization Form- to be completed and returned to your employer, if applicable
- HSA Debit Card(s) - If requested, your Debit Card(s) will arrive 7-10 business days from the date your account is opened. Your PIN(s) will arrive in a separate envelope.
- HSA Checks - your complimentary first order of checks will arrive 7-10 business days from the date your account is opened
- Online Banking- If requested, your PIN will arrive 7-10 days from the date your account is opened

* For questions about your eligibility to open an HSA, consult your tax advisor or consult the Department of Treasury's Web site at www.treas.gov/offices/public-affairs/hsa

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National City® | MEDICAL MUTUAL® | CONSUMERS LIFE INSURANCE COMPANY® A Medical Mutual of Ohio® Company

HSA Application

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. In addition, all U.S. persons will be required to provide a US Taxpayer Identification Number. We may also ask to see your driver's license or other identifying documents.

In all cases, protection of our customer's identity and confidentiality is National City's pledge to you.

APPLICANT INFORMATION

Title	First Name	MI	Last Name	Date of Birth	Social Security # (9 digits)
□ Mr. □ Mrs. □ Ms. □ Dr.				/ /	– –

Home Address (No P.O. Box)	City	State	Zip

Telephone (Home)	Telephone (Work)	Email

Employer Name	Mailing Address (if different than home address):

Insurance Carrier Name

Medical Mutual/CLIC

ADDITIONAL AUTHORIZED INDIVIDUAL (POA) INFORMATION:

Title	POA First Name	MI	Last Name	Date of Birth	Social Security # (9 digits)
□ Mr. □ Mrs. □ Ms. □ Dr.				/ /	– –

Home Address (No P.O. Box)	City	State	Zip

INITIAL HSA CONTRIBUTION:

Initial HSA Deposit $0- DO NOT SEND AN INITIAL DEPOSIT

ACCOUNT ACCESS:

Checks: You will receive a complimentary first order of checks

HSA Debit Cards:

□ Check here if you want a free HSA Debit Card

Check here if you want an additional free HSA Debit Card for your POA.

(Note: The Power of Attorney (POA) section of the HSA Signature Card must be completed.)

Online Banking:

□ Check here if you want to enroll in free Online Banking

BENEFICIARY DESIGNATION:

I hereby designate the following Primary beneficiary(ies) who survive me to receive the shares described below. Or if no share is indicated, it will be assumed to be divided equally. Contingent beneficiary(ies) who survive me to receive in equal shares, the sums described below. Please check Primary or Contingent for each individual beneficiary. If neither is checked, the individual will be deemed to be a Primary beneficiary. If any Primary or Contingent beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining beneficiary(ies) shall be increased on a pro rata basis. If no Primary beneficiary(ies) survives me, the Contingent beneficiary(ies) shall acquire the designated share of my HSA balance.

□ Primary □ Contingent Name			SS#
Spouse □ Yes □ No	Other	Date of Birth	Share %
□ Primary ¨ Contingent Name			SS#
Spouse □ Yes □ No	Other	Date of Birth	Share %
□ Primary □ Contingent Name			SS#
Spouse □ Yes □ No	Other	Date of Birth	Share %

TRUST/ESTATE BENEFICIARY:

□ Primary □ Contingent Name of Trustee or Estate		TIN
□ Trust or □ Estate	Date of Trust	Share %

Amounts payable at my death shall be distributed pursuant to the provisions in the HSA custodial agreement. I expressly reserve my unconditional right to revoke this Beneficiary Designation. It may be changed only by my signing a new Designation and filing it with the custodian, prior to my death. No divorce, marriage dissolution, separation or marriage annulment, whether occurring before or after the date of a beneficiary designation, shall have any effect upon any beneficiary designation, which shall remain in full force and effect until otherwise properly revoked or changed. In determining the identity or existence of any spouse or beneficiary, the Custodian shall be entitled to rely on an affidavit of the presumed spouse or beneficiary or other person (including a trustee).

Bank Use Only: □ Medical Mutual/CLIC program member, apply HSA-Medical Mutual payplan #14948

NationalCity®

Custodial Agreement

The account owner is establishing this health savings account (HSA) exclusively for the purpose of paying or reimbursing qualified medical expenses of the account owner, his or her spouse, and dependents. The account owner represents that, unless this account is used solely to make rollover contributions, he or she is eligible to contribute to this HSA; specifically, that he or she: (1) is covered under a high deductible health plan (HDHP); (2) is not also covered by any other health plan that is not an HDHP (with certain exceptions for plans providing preventive care and limited types of permitted insurance and permitted coverage); (3) is not enrolled in Medicare; and (4) cannot be claimed as a dependent on another person's tax return.

$0 initial dollars in cash is assigned to this custodial agreement. The account owner and the custodian make the following agreement:

Article I

1. The custodian will accept additional cash contributions for the tax year made by the account owner or on behalf of the account owner (by an employer, family member or any other person). No contributions will be accepted by the custodian for any account owner that exceeds the amount for family coverage plus the catch-up contribution.
2. Contributions for any tax year may be made at any time before the deadline for filing the account owner's federal income tax return for that year (without extensions).
3. Rollover contributions from an HSA, Archer Medical Savings Account (Archer MSA), HRA, FSA or IRA (unless prohibited under this agreement) need not be in cash and are not subject to the maximum annual contribution limit set forth in Article II.

Article II

1. For calendar year 2008, the maximum annual contribution limit for an account owner with single coverage is $2,900. For calendar year 2008, the maximum annual contribution limit for an account owner with family coverage is $5,800. These limits are subject to cost-of-living adjustments after 2008.
2. Contributions to Archer MSAs or other HSAs count toward the maximum annual contribution to this HSA.
3. For calendar year 2008, an additional $900 catch-up contribution may be made for an account owner who is at least age 55 and not enrolled in Medicare. The catch-up contribution increases to $1,000 in 2009 and later years.
4. Contributions in excess of the maximum annual contribution limit are subject to an excise tax. However, the catch-up contributions are not subject to an excise tax.

Article III

It is the responsibility of the account owner to determine whether contributions to this HSA have exceeded the maximum annual contribution limit described in Article II. If contributions to this HSA exceed the maximum annual contribution limit, the account owner shall notify the custodian that there exist excess contributions to the HSA. It is the responsibility of the account owner to request the withdrawal of the excess contribution and any net income attributable to such excess contribution.

Article IV

The account owner's interest in the balance in this custodial account is nonforfeitable.

Article V

1. No part of the custodial funds in this account may be invested in life insurance contracts or in collectibles as defined in section 408(m).
2. The assets of this account may not be commingled with other property except in a common trust fund or common investment fund.
3. Neither the account owner nor the custodian will engage in any prohibited transaction with respect to this account (such as borrowing or pledging the account or engaging in any other prohibited transaction as defined in section 4975).

Article VI

1. Distributions of funds from this HSA may be made at any time upon the direction of the account owner.
2. Distributions from this HSA that are used exclusively to pay or reimburse qualified medical expenses of the account owner, his or her spouse, or dependents are tax-free. However, distributions that are not used for qualified medical expenses are included in the account owner's gross income and are subject to an additional 10 percent tax on that amount. The additional 10 percent tax does not apply if the distribution is made after the account owner's death, disability, or reaching age 65.
3. The custodian is not required to determine whether the distribution is for the payment or reimbursement of qualified medical expenses. Only the account owner is responsible for substantiating that the distribution is for qualified medical expenses and must maintain records sufficient to show that the distribution is tax-free.

Article VII

If the account owner dies before the entire interest in the account is distributed, the entire account will be disposed of as follows: If all named beneficiaries predecease the account-owner, the account will pass to the contingent beneficiaries. If a beneficiary or contingent beneficiary is not named or all beneficiaries and contingent beneficiaries have predeceased the account-owner, the account will pass to the estate of the account owner.

1. If the beneficiary is the account owner's spouse, the HSA will become the spouse's HSA as of the date of death.
2. If the beneficiary is not the account owner's spouse, the HSA will cease to be an HSA as of the date of death. If the beneficiary is the account owner's estate, the fair market value of the account as of the date of death is taxable on the account owner's final return. For other beneficiaries, the fair market value of the account is taxable to that person in the tax year that includes such date.

Article VIII

1. The account owner agrees to provide the custodian with information necessary for the custodian to prepare any report or return required by the IRS.
2. The custodian agrees to prepare and submit any report or return as prescribed by the IRS.

Article IX

Notwithstanding any other article that may be added or incorporated in this agreement, the provisions of Articles I through VIII and this sentence are controlling. Any additional article in this agreement that is inconsistent with section 223 or IRS published guidance will be void.

Article X

This agreement will be amended from time to time to comply with the provisions of the Code or IRS published guidance. Other amendments may be made with the consent of the persons whose signatures appear below.

Article XI

If the account owner dies and the beneficiary or contingent beneficiary (whether or not named in the Agreement) is not the account owner's spouse, the HSA will cease (as described in Article VII) and the account will be closed and the amount will be distributed to the beneficiary or contingent beneficiary. Further if the account beneficiary is the account owner's spouse, the spouse will be required to open a new account

Account Owner's Signature ______________________________ Date ______________

Print Name ______________________________

By signing below, I am applying to open a Health Savings Account ("HSA") at National City Bank, Cleveland, Ohio ("National City"), and acknowledge receipt of the National City Health Savings Account Custodial Agreement. I agree to be bound by all of the terms and conditions contained in the Custodial Agreement as it may be amended from time to time, as well as any rules or other terms issued by National City in connection with the HSA. Further, I understand that this Application Form is subject to acceptance by National City understand that my HSA will be subject to the National City Personal Account Agreement which will be provided to me by National City when my HSA is opened. I agree to pay all fees applicable to my HSA and authorize National City to deduct such fees from my HSA. Please note that Medical Mutual/Consumers Life has no custodial role in your HSA funds.

If I checked either of the Debit Card boxes, I authorize National City to send me and/or my POA a Debit Card (Card) and a Personal Identification Number (PIN). I agree that each use of any Card and PIN shall be deemed authorization by me to National City to charge or credit my HSA for the amounts and types of transactions indicated at the time of use. If I checked the Online Banking box, I request that National City issue me an Initial Password that when used with my Logon ID will give me online access to my HSA. All instructions delivered by online access will be deemed to be my written authorization to charge or credit my HSA for the transactions indicated, and such transactions are subject to the Terms and Conditions governing Online Banking. All such transactions are also subject to the Personal Account Agreement referred to above. I agree that National City may deliver any and all disclosures required by law to be made to me electronically. I will immediately notify National City if the confidentiality of my Logon ID or Password is compromised.

Applicant ______________________________ Date: ______________

Print Name ______________________________

HSA Signature Card

Complete all lines indicated by an arrow.

Certification: The Taxpayer Identification Number provided below will be used to report required information to the Internal Revenue
➔ Service. Under penalties of perjury, I certify that: (1) My correct TIN is ____________________
and (2) I am not subject to backup withholding either 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, and (3) I am a U.S. person (including a U.S. resident alien). (You must cross out item 2 if you have been notified by IRS that you are currently subject to backup withholding because you failed to report all interest and dividends on your tax return.)

___ I am a Non-Resident Alien (Complete W-8BEN)

➔ Signature ______________________________ Date ______________________________

DEPOSITOR/LEGAL TITLE OF ACCOUNT	Date Opened	Date Revised	Account Number

CHECKING: Type of Account: HSA

☒ Personal

AGREEMENTS; BANK'S RIGHT OF SETOFF. Depositor(s) acknowledge receipt of the Personal Account Agreement, Pricing Schedule, and Rate Sheet, as applicable, completed, relative to the Account and agree to be bound thereby and by any amendments hereafter made. Each Depositor acknowledges that Bank is hereby given the right, before or after the death of any Depositor, to apply any balance in the Account to payment of any debit owing to Bank by any one or more Depositors.

APPOINTMENT OF POWER OF ATTORNEY (POA). Any attorney-in-fact (POA) whose name appears as appointed POA on this signature card is hereby authorized by each Depositor to (1) endorse, cash or deposit checks or other items payable to Depositor(s), (2) withdraw funds from the Account, and (3) give instructions on any matter in connection with the Account. This power of attorney shall terminate as to all Depositors when Bank receives written notice of termination from any Depositor. Actual notice to Bank of the death of any Depositor shall terminate this power of attorney only as to such deceased Depositor. Depositor agrees that the POA does not have the right to change the ownership of the Account or to change the ITF/POD or other beneficiaries of the Account. This power of attorney shall not be affected by the disability of any Depositor.

PAYABLE ON DEATH (POD)/IN TRUST FOR (ITF) BENEFICIARIES. Depositor(s) request that, upon the death of the last surviving Depositor and subject to Bank's right of setoff and to any relevant law, the designated share of the Account balance be paid to each beneficiary listed below who survives Depositor(s). The death of a beneficiary prior to the death of the last surviving Depositor revokes that beneficiary's designated share. Intervening divorce or dissolution of marriage does not terminate any beneficiary designation.

SIGNATURES OF ALL DEPOSITORS

➔ Depositor #1 ______________________________ Date ______________ ID Type #1 Non-Documentary

Print Name ______________________________

PENNSYLVANIA POA: If a POA is appointed and this signature card is signed in Pennsylvania by any Depositor or POA, this section must be completed.
NOTICE: THE PURPOSE OF THIS POWER OF ATTORNEY IS TO GIVE THE PERSON YOU DESIGNATE (YOUR "AGENT") BROAD POWERS TO HANDLE YOUR PROPERTY, WHICH MAY INCLUDE POWERS TO SELL OR OTHERWISE DISPOSE OF ANY REAL OR PERSONAL PROPERTY WITHOUT ADVANCE NOTICE TO YOU OR APPROVAL BY YOU. THIS POWER OF ATTORNEY DOES NOT IMPOSE A DUTY ON YOUR AGENT TO EXERCISE GRANTED POWERS, BUT WHEN POWERS ARE EXERCISED, YOUR AGENT MUST USE DUE CARE TO ACT FOR YOUR BENEFIT AND IN ACCORDANCE WITH THIS POWER OF ATTORNEY. YOUR AGENT MAY EXERCISE THE POWERS GIVEN HERE THROUGHOUT YOUR LIFETIME, EVEN AFTER YOU BECOME INCAPACITATED. UNLESS YOU EXPRESSLY LIMIT THE DURATION OF THESE POWERS OR YOU REVOKE THESE POWERS OR A COURT ACTING ON YOUR BEHALF TERMINATES YOUR AGENTS AUTHORITY. YOUR AGENT MUST KEEP YOUR FUNDS SEPARATE FROM YOUR AGENTS FUNDS. A COURT CAN TAKE AWAY THE POWERS OF YOUR AGENT IF IT FINDS YOUR AGENT IS NOT ACTING PROPERLY. THE POWERS AND DUTIES OF AN AGENT UNDER A POWER OF ATTORNEY ARE EXPLAINED MORE FULLY IN 20-PA.C.S. CH.56. IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER OF YOUR OWN CHOOSING TO EXPLAIN IT TO YOU. I HAVE READ OR HAD EXPLAINED TO ME THIS NOTICE AND I UNDERSTAND ITS CONTENTS.

➔ DEPOSITOR #1 (PRINCIPAL) ______________________________ Date ______________

I, ______________________________, HAVE READ THE ATTACHED POWER OF ATTORNEY AND AM THE PERSON IDENTIFIED AS THE AGENT FOR THE PRINCIPAL. I HEREBY ACKNOWLEDGE THAT IN THE ABSENCE OF A SPECIFIC PROVISION TO THE CONTRARY IN THE POWER OF ATTORNEY OR IN 20. PA.C.S. WHEN I ACT AS AGENT:
I SHALL EXERCISE THE POWERS FOR THE BENEFIT OF THE PRINCIPAL.
I SHALL KEEP THE ASSETS OF THE PRINCIPAL SEPARATE FROM MY ASSETS.
I SHALL EXERCISE REASONABLE CAUTION AND PRUDENCE.
I SHALL KEEP A FULL AND ACCURATE RECORD OF ALL ACTIONS, RECEIPTS, AND DISBURSEMENTS ON BEHALF OF THE PRINCIPAL.

➔ DEPUTY (AGENT) ______________________________ Date ______________

SIGNATURE OF APPOINTED POWER OF ATTORNEY (If POA Desired)

➔ Printed P.O.A. Name ______________________________

➔ Signature of P.O.A. ______________________________

HSA Contribution Authorization

(Group Enrollees only if required by your employer)

Upon receipt of your Welcome Kit complete this form and return to your Human Resources officer, or as otherwise directed by your employer in order for your employer to initiate contributions to your HSA. Do Not Return to National City.

Employee Information:

First Name	M.I.	Last Name

Employee ID or Social Security Number	Work Phone Number

Bank Information:

Name of Financial Institution: National City Bank

Routing & Transit Number (see sample below) ____________________ HSA Account Number ______________

Account Type: Checking

AUTHORIZATION AGREEMENT

I hereby authorize my employer to send HSA contributions directly into the account named above. This authority will remain in force until I have given written notice that I have terminated it or until my employer has notified me that this deposit service has been terminated. I understand that I must give advance notice to allow reasonable time for my instructions to be executed. If ever an incorrect amount should be entered into my account, I authorize my bank to make the appropriate adjustment.

Employee Signature: ______________________________________ Date ____________________

Health Savings Account

1234

Name
Address
Phone Number

PAY TO THE ORDER OF ______________________________ $ __________

______________________________ DOLLARS

National City
National City Bank
Cleveland, Ohio

Memo ______________________________

⑆123456789⑆ 123456789⑈ 1234

Routing & Transit #

HSA #

71-1191-00 (Rev. 10/31/07)