HEALTH SAVINGS ACCOUNT (HSA) APPLICATION

OptumHealthBank℠

myuhc.com® Toll-Free phone: 1-800-791-9361

To avoid processing delays, please complete all fields on the application – starred fields (*) are required.

Mail your completed application (and opening deposit, if applicable) to:
OptumHealth Bank, P.O. Box 30777, Salt Lake City, UT 84130

Or fax both sides of this form to: 1-800-765-6766
And mail opening deposit , if applicable, separately to:
OptumHealth Bank, P.O. Box 271629, Salt Lake City, UT 84127

PART 1: PERSONAL INFORMATION – ACCOUNT HOLDER

*Social Security # / Tax Identification #	*Date of Birth (mm/dd/yyyy)
___ - ___ - ____	__ / __ / ____

*First Name	Middle Initial	*Last Name

*Street Address (cannot be a PO Box)	Apt #	*City	*State	*ZIP

Mailing Address (if different than street address)	Apt #	City	State	ZIP

*Home Phone	Work Phone
(___) ___ - ____	(___) ___ - ____ ext. ____

*Verification Code (such as your Mother's Maiden Name) To be Used for Security Purposes – Up to 10 Letters	E-mail Address

PART 2: REQUEST FOR ADDITIONAL DEBIT CARD (OPTIONAL)

If you wish to request a Health Savings Account Debit MasterCard® for use by an authorized user – either your spouse or another eligible dependent – please complete the section below.

Authorized User's First Name	Middle Initial	Last Name

*Date of Birth (mm/dd/yyyy)	*Social Security # / Tax Identification #
__ / __ / ____	___ - __ - ____

PART 3: HIGH DEDUCTIBLE HEALTH PLAN (HDHP)/MEDICAL PLAN INFORMATION

*Medical Insurance Company or Carrier	*Medical Insurance Plan or Group #

HDHP Member Identification # (you may find on your ID card)	*HDHP Effective Date
	__ / __ / ____

*Who is covered? (check one): ☐ Individual ☐ Family [Individual + Dependent(s)]

*Are you Enrolling in an HSA through your Employer? (check one): ☐ Yes ☐ No	If Yes, Provide your Employer's Name:

PLEASE TURN PAGE OVER AND COMPLETE BOTH SIDES OF THIS APPLICATION >

PER THE USA PATRIOT ACT:

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. When you open the account, we will ask for your name, street address, date of birth and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

Form of Identification (check one):	Identification #	State of Issuance
☐ Driver's License ☐ State ID ☐ Passport		

PART 4: BENEFICIARY INFORMATION (OPTIONAL)

If you do not designate otherwise, your estate will be the beneficiary of your HSA upon your death. To designate an alternative beneficiary, please complete a Designation of Beneficiary form, available on myuhc.com or request one from customer service at 1-800-791-9361.

PART 5: REQUIRED SIGNATURE (Please Read Before Signing)

By signing below, I acknowledge and certify that:

- I wish to establish a health savings account ("HSA") with OptumHealth Bank as custodian.
- I understand the eligibility requirements for deposits made to my HSA and state that I qualify to make deposits to this account. I have reviewed this application and understand and agree that my HSA will be opened under and governed by OptumHealth Bank's Custodial and Deposit Agreement and that the terms and conditions therein will be binding on me. This document will be sent to me when my account is opened, along with OptumHealth Bank's Privacy Policy and Schedule of Fees.
- I authorize OptumHealth Bank to provide information about my HSA, including my account number, to my employer (if applicable) and those acting on behalf of my employer or OptumHealth Bank (if applicable), in connection with the establishment and maintenance of my HSA.
- I acknowledge that my employer and all others acting on behalf of my employer (if applicable), may provide information on my behalf to establish and maintain my HSA and authorize my employer and its designee to take such action deemed necessary and appropriate by my employer to administer my HSA, including but not limited to, effectuating deposits and correcting errors where necessary.
- I understand my monthly account statements will be made available to me electronically. I agree to notify OptumHealth Bank if I wish to have statements mailed to my home address.
- I have requested a Health Savings Account (HSA) Debit MasterCard and if I have filled out the information to request an additional debit card, I hereby request OptumHealth Bank to issue a debit card on my account to the person indicated and I acknowledge I will be liable for the use of the debit card by the Authorized User.
- I certify that the information provided in this application is true and complete.

X_____ _____

*Account Holder – Signature Required Date

IMPORTANT: We cannot process this application without your signature.

PART 6: OPENING DEPOSIT

Opening deposit enclosed with application (if applicable) (check one): ☐ Yes ☐ No Amount $:_____

If you are an individual mailing an opening deposit for your own HSA, please write your name and social security number on the check.