First HSA
2561 Bernville Rd.
Reading, PA 19605
(Ph) 610-678-6000 or 888-769-8696
(Fax) 610-678-6818
Website: www.1hsa.com

Agent Name: ______________

Agency: ______________

Agents must sign up at www.1hsa.com

Health Savings Account Application

Applicant Information

*First Name	Middle Initial	*Last Name	*Soc. Sec. #	*Date of Birth (mm/dd/yyyy)
*Address (if P.O. Box – also provide street address)		*City	*State	*Zip: -
*Driver's License # or State ID#	*State:	*Issue Date:	*Expiration Date:	
*Home Phone:	Business Phone:	E-mail Address:	Gender: ☐Male ☐Female	
Company Name	Phone Number	Contact Person	Email Address	
Company Address	City	State	Zip Code	

Designation of Beneficiaries

Designation of Beneficiaries: I hereby certify that if I die before distribution has been completed, the value of my Health Savings Account shall be distributed to the Beneficiaries named below. Use a separate paper for additional beneficiaries.

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

Authorized Signor

Authorized Signor (optional) – I hereby designate the following individual as additional authorized signor on my Health Savings Account

Primary Name	Soc. Sec #	Relationship	Date of Birth

☐Order Additional Check Card–Your account will be debited $5 for the additional card.

Fees and Deposits

Insurance Company Emblem Health	Plan Type ☐ Individual ☐ Family	Annual Deductible	Effective Date

*Fee Type
☐ E-statement – receive statements via email - see below
☐ Paper statement – receive statements via US Postal Service

☒Check here to receive initial order of 20 free checks

***To sign up for e-statements, enter your email address and finalize setup with instructions provided in your welcome kit.** *Email Address

Please remit with application: Make one check payable to "First HSA" This check should include any current year contributions. During a promotional period, First HSA is waiving our monthly administration fee as long as the current Insurance Plan remains in force. This promotion is subject to change without notification. Once the promotional period has ended or the current Insurance has been terminated, First HSA administration fees will be charged at the current rate. **A minimum opening deposit of $50.00 is required when contributing by check.** No minimum opening balance is required if contributing through direct deposit or payroll deduction.

Direct Deposits – no dates allowed after the 28th of the month - Attach a voided check or enter personal account information:
Routing # ______________ Account # ______________

☐ **One Time** Date ____	☐ **Bi Weekly** – select 2 days of the month day____ & day____	☐ **Monthly** – select the day of the month day____	☐ **Annually** Date ____

Disclaimer and Signature

***TIN Certification:** Under penalties of perjury, I certify that the social security number shown on this form is my correct taxpayer identification number
☐ 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 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 US Citizen or resident alien.
☐ I am subject to backup withholding because I have been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest and dividends and I am a US Citizen or resident alien
The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Health Savings Account Adoption Agreement: This agreement when signed by me and accepted by First HSA acting as an agent for VIST Bank, as Custodian, incorporates the VIST Bank HSA Custodial Agreement (the "HSA Agreement"). By signing this Agreement, I acknowledge: 1) That there are fees for the First HSA 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 HSA has no duty to determine the investment, tax or other consequences resulting from my actions involving my HSA. 6) That First HSA is not an insurance company who offers the high deductible insurance plans. 7) That I will receive a copy of the HSA Custodial Agreement and Disclosures, Electronic Fund Transfer Agreement and Disclosure, Check and Funds Availability Disclosure (if you request checks), Account Agreement, Truth in Savings Disclosure and Your Financial Privacy at VIST Financial Corp. **(Member FDIC) – All account holders will receive a VISA check card upon account opening.**

***Signature**	**Date**

*required fields

Revised 11/21/08

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Employer Set-Up Form

General Company Information

Company Name		Effective Date
Company Address, City, State, Zip code, Phone Number		Number of Employees (Eligible)
Contact Name		Phone #
Secondary Contact Name (If applicable)		Phone #
Agent/Broker Name, Address, City, State, Zip code		Phone #

Contribution Information

- ☐ **Employee Contribution**
  - ☐ Payroll Deduction
  - ☐ Individual Payments
    - ☐ Check
    - ☐ Direct Deposit

- ☐ **Employer Contribution**
  - ☐ Payroll Deduction
  - ☐ Employer Check (Groups below 50 enrolled only)
  - ☐ Electronic Funds Transfer (EFT)

Administration Fees

☐ **Employee Paid** ☐ **Employer Paid**

Health Insurance Plan:

Insurance Company: ______________________________

Deductible/s: ____ **Indiv:** __________ **Fam:** ________________

Form 10050

Revised 11/25/08

Group Name:

Effective Date:

☐ Policy year
☐ Calendar year (renewals only)

Network:

National

Rating Structure:

Sole Proprietors
☐ 2-Tier

Groups of 2-50
☐ 2-Tier
☐ 4-Tier

Plan Options:

	☑ Plan Selection		In-network Deductible	In-network Coinsurance	In- Network OOP Max	Prescription Coverage Generic/Preferred/ Non Preferred
1	☐*	Individual	$1,150	80%	$3,650	After deductible $0/$20/$40
		Family	$2,300	80%	$7,300	After deductible $0/$20/$40
2	☐*	Individual	$2,500	100%	$2,500	After deductible covered in full
		Family	$5,000	100%	$5,000	After deductible covered in full
3	☐*	Individual	$3,000	100%	$3,000	After deductible covered in full
		Family	$5,950	100%	$5,950	After deductible covered in full
4	☐	Individual	$5,800	100%	$5,800	After deductible covered in full
		Family	$11,600	100%	$11,600	After deductible covered in full

***Plans not available to Sole Proprietors**

Home Delivery 2x

	In-Network
Annual Max	None
Lifetime Max	None
Allowed Charge	Fee Schedule
Dependent/Student	19/25

Required /Riders

PLHSGC 997 Certificate

PLHSGC 998B Attachment

PLA 96 Extended Student Coverage
PLA 16A Domestic Partner Coverage
PLA86A In-Hospital Medical Services
PLA 117 Skilled Nursing Mandate
PLA 121 Medicare Language

PLA 70 Contraceptive Coverage
PLA106 Mental Health
PLA 112 Changes to Policy Year
PLA 120 IP Chem Dep

Required Pharmacy Riders

PLHSGC1002 Pharmacy Rider for plan 1
PLHSGC1002 **Z** Pharmacy Rider for plans 2,3,and 4
PLA 66C Prior Authorization
PLA 102 Specialty Pharmacy Program