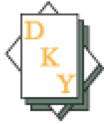

David K. Young Consulting
BENEFIT CONSULTING & ADMINISTRATION

HSA Enrollment Form

Employer:	
Effective Date:	Date of First Payroll:

Employee Information

First Name* | Last Name* | SSN*

Address* | Apt Number

City | State | Zip

Phone Number* | Email Address* | Date of Birth*

HSA Authorized Signer (optional) – *If you want your spouse or other party to have access to the HSA, please complete the following section with the authorized signer's information. If you are unable to provide all of the required information on your authorized signer, he or she 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 DKYC and the Custodian regarding your HSA; make deposits or withdrawals by any means acceptable to the Custodian, 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 HSA. You specifically authorize DKYC and the Custodian, to rely upon this authorization and designation until such time, if any, that DKYC 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 HSA Account Documents which have been provided to you. You hold harmless and indemnify DKYC and the Custodian against any claims against or losses the Custodian may suffer arising out of DKYC's and the Custodian's reliance on this authorization, and release DKYC 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 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.*

Authorized Signer Name | Date of Birth | SSN

Contributions

I request the following to be deducted from my pay pre-tax:	Per Pay Period Election		Current High Deductible Health Plan (HDHP) Coverage
HSA	$		☐ Employee Only ☐ Employee plus dependents

Beneficiary Designation

A. **Primary Beneficiaries.** In the event of my death, pay my HSA balance to the following primary beneficiaries according to the percentages indicated. If more than one primary beneficiary is designated and no percentages are indicated, the beneficiaries will be deemed to own equal share percentages in the HSA. If a primary beneficiary dies before me, his or her share shall be reallocated on a pro-rata basis to any remaining primary beneficiaries.

Name & Address	SSN	Relationship	Date of Birth	Percentage

B. **Contingent Beneficiaries.** If all of my primary beneficiaries die before me, pay my HSA balance to the following contingent beneficiaries according the percentages indicated. If a contingent beneficiary dies before me, his or her share be reallocated on a pro-rata basis to any remaining contingent beneficiaries.

Name & Address	SSN	Relationship	Date of Birth	Percentage

By signing below, I certify that:

(1) 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 dependent on another person's tax return (excluding spouses per the IRS).
(2) WealthCare Saver Prime is hereby appointed to serve as custodian of my Health Savings Account.
(3) I understand that I will receive all applicable disclosures via email or may request them from the Administrator, DKYC. Upon receipt, I will review and agree to the terms and conditions outline therein. Within seven (7) calendar days from the date I open this HSA, I may revoke authorizations for opening the account by mailing written notice to DKYC, 11118 Wurzbach Rd, Ste 300, San Antonio, TX 78230.
(4) I am a U.S. citizen or other U.S. person (including U.S. resident alien).
(5) I understand that 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.
(6) I understand account statements are delivered by both paper and electronic and I can change delivery preference once enrolled for online access. I understand that there is a fee for paper delivery and that the fee will be waived once I opt-out of paper delivery.
(7) The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me).
(8) 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.
(9) I will consult with my tax or legal advisor if I need advice. I acknowledge that the Custodian and Administrator named above cannot and does not provide me with tax or legal advice. I am solely responsible for determining the tax consequences of all distributions.
(10) I acknowledge and agree that the Custodian and/or Administrator may share limited information with my employer or insurance agents.

By signing below I agree to all applicable HSA Terms and Conditions and that all information I have provided is true and correct. I release and agree to hold the Custodian harmless against any and all claims or losses arising from my actions. Please open my account.

EMPLOYEE SIGNATURE　　　　　　　　DATE