

# APPLICATION & BENEFICIARY DESIGNATION FORM

## MyHSA HEALTH SAVINGS ACCOUNT

**The Charles Schwab Trust Company is Custodian  
Administrated by Alliance Benefit Group of Illinois**

**(PLEASE PRINT)**

Please complete this Application & Beneficiary Designation Form for the Alliance Benefit Group (ABG) Health Savings Account Program and return it to your Employer.

ACCOUNT HOLDER INFORMATION		
Name: (First):	(MI):	(Last):
Address #1		
Address #2:		
City / State / Zip:		
Mailing Address: (if different from above)		
City / State / Zip:		
Home Phone:	Work Phone:	
E-mail Address:		
Social Security Number:	Date of Birth:	
EMPLOYER INFORMATION		
Employer Name:		
Address:		
City:	State:	Zip:
ELIGIBILITY INFORMATION (YOU MUST CHECK YES ON THE QUESTION BELOW TO BE ELIGIBLE FOR AN HEALTH SAVINGS ACCOUNT. IF YOU ANSWERED NO, PLEASE SEE YOUR BENEFITS ADMINISTRATOR FOR MORE DETAILS)		
<input type="checkbox"/> Yes <input type="checkbox"/> No <b>I am currently an eligible individual as described in the Custodial Agreement into which this Application is incorporated. I understand that maintaining my eligibility is my responsibility and that Alliance Benefit Group and The Charles Schwab Trust Company assumes that all contributions are made while I am eligible to participant in a qualified Health Savings Account.</b>		

### ADOPTION AGREEMENT

This application is for the establishment of my individually owned Health Saving Account at The Charles Schwab Trust Company. I understand that by signing this Application, I am acknowledging that I have received and reviewed the Alliance Benefit Group Health Savings Account Custodial Agreement and agree to be bound by the terms of this agreement. In accordance with the terms and conditions of this agreement, I am requesting Alliance Benefit Group to establish a Health Savings Account on my behalf with The Charles Schwab Trust Company as Custodian. I further understand and acknowledge that my Health Savings Account is not effective until it has been accepted by Alliance Benefit Group. **I acknowledge that in the absence of a signed HSA Investment Election Form, all contributions eligible for investment (as defined within the Alliance Benefit Group Health Savings Account Individual Custodial Agreement) will be invested in a MetLife Guaranteed Fund.** The information on this application is true and accurate to the best of my knowledge and I submit this form with full understanding and acceptance of the provisions contained within the Custodial Agreement. I also acknowledge that Alliance Benefit Group is authorized to perform transactions on my account and all such transactions initiated by Alliance Benefit Group should be treated as if initiated directly by me, the Account Holder.

Signature of Account Holder: \_\_\_\_\_ Date: \_\_\_\_\_

## BENEFICIARY DESIGNATION

Pursuant to the Custodial Agreement, you are authorized to designate one or more individuals as a Designated Beneficiary(ies) of your account. For each designated person below, include their address, city, state, zip, social security number and relationship to you in the space provided. You must also designate a percentage of your remaining account (if any) to be distributed to that individual. If you need additional space to appoint additional Designated Beneficiary(ies), please contact our Customer Service Center to request an expanded Beneficiary Designation Form. **NOTE: All percentages must add up to 100%**

PRIMARY BENEFICIARY(IES)			
Name:		%:	
Address:	City:	State:	Zip:
SSN:	Relationship:		

If all individuals listed as Primary Beneficiaries precede you in death or cannot be located after a reasonable search by the Custodian (or its designee), all non allocated funds (if any) from your account will be distributed to your Contingent Beneficiary(ies) designated below. In the event that no beneficiary can be located, your account balance (if any) will be distributed to your estate.

CONTINGENT BENEFICIARY(IES)			
Name:		%:	
Address:	City:	State:	Zip:
SSN:	Relationship:		

Note: Special rules apply in certain states if a married individual does not select his / her spouse as beneficiary. If you reside in a community or marital property state and you designate a person other than your spouse as beneficiary, you must obtain authorization from your spouse. It is the responsibility of the Account Holder to ensure that the individual(s) designated as beneficiary (ies) are legally authorized to act in that fashion. Neither the Custodian nor ABG accept responsibility for erroneously named beneficiaries.

ALLIANCE BENEFIT GROUP OF ILLINOIS, PROGRAM ADMINISTRATOR:
<b>Alliance Benefit Group of Illinois</b> <b>MyHSA Application</b> <b>456 Fulton Street, Suite 345, Peoria, IL 61602</b>

THE CHARLES SCHWAB TRUST COMPANY, CUSTODIAN:
<b>215 Fremont Street, 6<sup>th</sup> Floor, San Francisco, CA 94105</b>

### RETURN YOUR COMPLETED APPLICATION TO

You can mail your completed application to Alliance Benefit Group of Illinois at the address above or you can fax your completed application to 800-688-4329. If you have any questions please call our customer service at 800-57-MyHSA (1-800-576-9472).

## MYHSA CONTRIBUTION

Please elect only one contribution option.

- Payroll deduction in the amount of \$ \_\_\_\_\_ per payroll (This option must be setup through your employer).
  
- I hereby authorize Alliance Benefit Group, program administrator, to initiate monthly debit entries as direct deposit (EFT) withdrawal (as my HSA Contribution) in the amount of \$ \_\_\_\_\_ (If you will be making monthly EFT contribution, you will need to also complete the HSA ELECTRONIC FUNDS TRANSFER (EFT) CONTRIBUTION AUTHORIZATION FORM).
  
- I will be making a one time annual contribution in the amount of \$ \_\_\_\_\_. (If you will be making a one time annual contribution you will need to also complete the HSA ANNUAL CONTRIBUTION AUTHORIZATION FORM).

**Signature of Account Holder:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ELECTRONIC FUNDS TRANSFER (EFT)  
CONTRIBUTION AUTHORIZATION FORM**  
(PLEASE PRINT)

<b>ACCOUNT HOLDER INFORMATION</b>		
Name: (First):	(MI):	(Last):
Social Security Number:		

I hereby authorize Alliance Benefit Group, program administrator, to initiate monthly debit entries as electronic funds transfer (EFT) withdrawal (as my HSA Contribution) and to initiate, if necessary, credit adjustment entries made for any debit entry made in error to my account. These debit transactions will begin monthly on the first or fifteenth business day of each month (as selected below) following receipt of this authorization. All HSA account holders are required to use EFT monthly withdrawal for ongoing contributions to their HSA Account and are responsible for assuring there are sufficient funds available in their account at the time of withdrawal.

\_\_\_\_\_  
Name of Financial Institution

\_\_\_\_\_  
Routing and Transit Number (9 Digits)

\_\_\_\_\_  
Account Number     *(Authorization applies to  
checking accounts only)*

**Contribution Date:**

\_\_\_\_\_ 1<sup>st</sup> Business Day of each Month

\_\_\_\_\_ 15<sup>th</sup> Business Day of each Month

This authorization remains in full force and effect until which time Alliance Benefit Group has received written notification from me of its termination. I agree to provide such notification of cancellation in such manner as to afford Alliance Benefit Group reasonable time to act on it.

Signature of Account Holder: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*AN ACTUAL VOIDED CHECK MUST BE ATTACHED\*\***

# HSA ANNUAL CONTRIBUTION AUTHORIZATION FORM (PLEASE PRINT)

This is a contribution for (check one):  Current Year Or  Previous Year

(Funds must be received prior to April 15<sup>th</sup> to qualify as a previous year contribution)

ACCOUNT HOLDER INFORMATION		
Name: (First):	(MI):	(Last):
Social Security Number:		
Address:		
City / State / Zip:		
Contribution For Calendar Year Ending:		
Contribution Amount: \$		

**ACH INSTRUCTIONS:**

BANK OF AMERICA NT & SA  
SAN FRANCISCO, CA  
ABA# 121000358  
PAYEE: THE CHARLES SCHWAB TRUST CO. (CTSC)  
CREDIT TO: ACCT# 12337-11961  
FOR FURTHER CREDIT: ACCT # 201892

**MAILING INSTRUCTIONS:**

CHECK PAYABLE TO: THE CHARLES SCHWAB TRUST COMPANY (CTSC)  
ON THE CHECK SOMEWHERE PUT: FOR CREDIT TO ACCT # 201892

MAIL CHECK TO:  
ALLIANCE BENEFIT GROUP OF ILLINOIS  
MYHSA DEPARTMENT  
456 FULTON STREET, SUITE 345  
PEORIA, IL 61602

**MAIL OR FAX A COPY OF THIS FORM TO:**

ALLIANCE BENEFIT GROUP OF ILLINOIS  
MYHSA DEPARTMENT  
456 FULTON STREET, SUITE 345  
PEORIA, IL 61602  
FAX ( 800 ) 688-4329

QUALIFIED PRIOR YEAR HSA CONTRIBUTIONS MUST BE RECEIVED BY THE CHARLES SCHWAB TRUST COMPANY ON OR BEFORE APRIL 15<sup>th</sup> OF THE CURRENT CALENDAR YEAR

MyHSA Account Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# AUTHORIZATION FOR DIRECT DEPOSIT (EFT) CLAIM/DISTRIBUTION PROCESSING

HSA Account Holder: \_\_\_\_\_

Your SS#: \_\_\_\_\_

I hereby authorize Alliance Benefit Group as program administrator to initiate credit entries as direct deposit claim reimbursements and to initiate, if necessary, debit adjustment entries made for any credit entry made in error to my account. Direct Deposit Claim/Distribution Processing may be made for any Qualified Reimbursement Arrangements as defined within Section 125; Section 223 or Section 132 of the Internal Revenue Code. These arrangements include Health Savings Accounts, Medical Spending Accounts, Dependent Care Reimbursement Accounts, Insurance Premium Reimbursement Accounts and/or Transportation Reimbursement Accounts.

_____	Type of Account
Name of Financial Institution	(Authorization applies to checking accounts only )
_____	
Routing and Transit Number ( 9 Digits)	
_____	
Account Number	

This authority shall apply to all request for claim reimbursements and distribution processing I submit to Alliance Benefit Group under the programs listed above. This authorization remains in full force and effect until which time Alliance Benefit Group has received written notification from me of its termination. I agree to provide such notification of cancellation in such manner as to afford Alliance Benefit Group reasonable time to act on it.

\_\_\_\_\_  
Signature

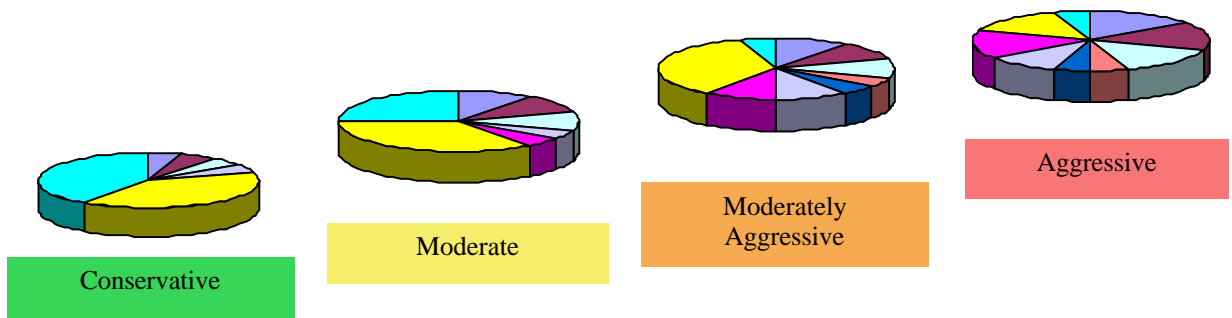
\_\_\_\_\_  
Date

**\*\*AN ACTUAL VOIDED CHECK MUST BE ATTACHED\*\***

# INVESTMENT ELECTION FORM

## ABG HEALTH SAVINGS ACCOUNT (HSA) FUNDS

Your Name \_\_\_\_\_ SS# \_\_\_\_\_  
 (Please Print)



Select a single Investment Strategy by placing an "x" in the box under your selection.			Conservative	Moderate	Moderately Aggressive	Aggressive	Custom
Funds	Investment Category		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allianz OCC Value D	Large Value PVLDX		5%	10%	10%	15%	
Davis NY Venture	Large Blend NYVTX		5%	10%	10%	15%	
Schwab S&P 500 inv	Large Blend Index SWPIX						
Growth Fund of America F	Large Growth GFAFX		5%	10%	10%	15%	
ABN AMRO Mid Cap N	Mid-Cap Blend CHTTX				10%	10%	
Munder Small-Cap Value A	Small Blend MNVAX			5%	10%	10%	
Thornburg International A	Foreign Blend TGVAX		5%	5%	10%	15%	
Bond Fund of America F	Interm. Government BFAFX		40%	35%	35%	15%	
AmerCent Inflation Adj Bond Inv	Interm. Government ACITX						
Phx Duff & Phelps Real Estate A	Specialty Real Estate PHRAX						
MetLife Guaranteed Fund	Fixed Rate METABG-IL		40%	25%	5%	5%	
<b>TOTAL</b>			<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, I certify that the above information is accurate and correct.

\_\_\_\_\_ SIGNATURE