

Application for an Employee Health Savings Account

GroupCare or Congregational Employee Plan

Please provide the following information. Note that we will use your telephone number or e-mail address only if we have questions about your responses on this application.

Employer _____

Employee name _____
First middle last

Social Security number _____ Telephone number _____

E-mail address _____

Beneficiary designation

If you want your spouse to be able to keep the HSA active at your death, you need to name him or her as the **only** primary beneficiary. Please also name at least one secondary beneficiary.

If you are not married or keeping the account active is not an issue for your family, please name at least one primary and one secondary beneficiary. You may name an estate or trust* if you so choose.

Failing to name a beneficiary can result in adverse tax consequences for your spouse or estate.

You can change your beneficiary designation any time and as often as you wish. Any change of beneficiary, however, must be in writing, subject to any rules we establish, and is not effective until we receive it.

If your spouse or any other person acquires your interest in the HSA on your death other than as a *designated* beneficiary, the account will cease to be an HSA on the date of your death and the amounts distributed will be includible in the gross income of the person acquiring them.

If no primary beneficiary is living at the time of your death, the remaining funds will be paid to the secondary beneficiary(ies). The secondary beneficiary(ies) will not receive any benefits if one or more named primary beneficiary(ies) are still living at the time of your death. If no primary or secondary beneficiary survives you or if no beneficiary designation is in effect at your death, your estate will acquire your interest in your HSA.

The above information is a summary. For complete information on the administration of your HSA in the event of your death, please refer to the *Disclosure Statement and Custodial Agreement*.

**If you designate a trust as the beneficiary, you will need to provide the name and address of each trustee, the date the trust was established, the name of the trust, and the trust's taxpayer identification number.*

Primary beneficiaries

Name	Relationship	Birth date	Social Security number	Share

Secondary beneficiaries

Name	Relationship	Birth date	Social Security number	Share

Signature

I understand that:

1. Eligibility for the tax advantages of an HSA is a matter of tax law.
2. This HSA is created primarily for me as the account holder and my family and is used generally for qualifying medical expenses.
3. MMA Insurance Company (MMA), as custodian of the account, does not act as overseer to determine whether distributions from my HSA are for qualified medical expenses.
4. MMA does not assume any tax liability for actions taken by me in regards to my HSA.
5. I must be enrolled in a qualified high-deductible health plan on the first day of the month to be eligible to make a contribution to my HSA for that month.
6. It is my responsibility to understand and operate this HSA within the guidelines of the Internal Revenue Service (IRS).
7. The terms and conditions that apply to this HSA are contained in this application and the *Disclosure Statement and Custodial Agreement* I will receive upon enrollment.

Further, I acknowledge that I have completed the Eligibility Worksheet for Health Savings Accounts or consulted my tax advisor and verify I have determined that I am eligible for an HSA. I also acknowledge that neither MMA nor any licensed counselor has provided me with any tax advice or given any legal opinion regarding any use of the funds in the HSA.

Signature _____

Date _____



MMA[®]

1110 North Main Street
Post Office Box 483
Goshen IN 46527

Toll-free: (800) 348-7408
Telephone: (574) 535-0611
www.mma-online.org