HSA ENROLLMENT FORM

Instructions

1. Complete this form in order to open an HSA. (***** = Required Fields)
2. Submit to designated personnel.
3. If you have any questions regarding this form, please call **877-933-3539.**

Accountholder Profile Information

Employer/Company Name

*Name (Last, First, MI)

*Social Security Number

*Employee ID

*E-mail Address

*Address Line 1 (cannot be PO Box)

*Address Line 2 (cannot be PO Box)

*City *State *Zip

*Home Phone

*Daytime Phone Number

*Date of Birth

☐ Male ☐ Female
*Gender

☐ Married ☐ Single
*Marital Status

*Mother's Maiden Name

*Hire Date

*Hours Worked Per Week

*Payroll Frequency

Election

Please choose one of the following enrollment options.

☐ I am enrolling in an HSA through my employer. I authorize my employer to deduct my HSA contributions from my pay and forward them to my HSA. (Please complete the section immediately below.)

Note: Your employer may also make a contribution to your HSA that will apply to your maximum contribution allowed. You are solely responsible for determining whether contributions to an HSA exceed the maximum annual contribution limitation. You are also responsible for notifying the custodian of any excess contribution and requesting a withdrawal of the excess contribution together with any net income attributable to the excess contribution.

*Indicate an annual employee election **or** a pay period election: $ Employee Annual Contribution **or** $ Per Pay Period Contribution

*Indicate HDHP Coverage Level: ☐ Self-only or ☐ Family/Other

*Indicate if you are enrolled in an HDHP through your employer: ☐ Yes or ☐ No

Your contributions will be withdrawn from your pay in each pay period. If your employer maintains a cafeteria plan that permits HSA contributions, your contributions will be made with pre-tax dollars. You may also make contributions outside of your employment. If you would like to make a contribution immediately, please complete an HSA Contribution Form and submit that form with your payment.

A $5.50 monthly admin fee applies to all accounts.

Direct Deposit Setup

This section is required if you have chosen Direct Deposit as your HSA Reimbursement Method above.

*Bank Name

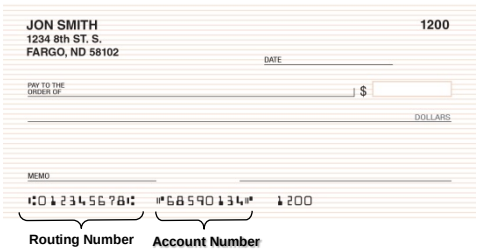
*Address | *City | *State | *Zip

☐ Checking ☐ Savings
*Account Type

*Routing Number

*Account Number

*



Beneficiary Designation and Information

I designate the following individual(s) or entity as my primary or contingent death beneficiary(ies) of this HSA. If I am married in common law or in a community or marital property state, I must designate my spouse as my Primary Beneficiary unless spouse's signature is obtained and notarized below. Share percentages must equal 100% for primary and 100% for contingent.

No.	Name and Address	Date of Birth	Social Security Number	Primary or Contingent	Relationship	Share %
1.				☐ Primary ☐ Contingent	☐ Spouse ☐ Dependent ☐ Other	
2.				☐ Primary ☐ Contingent	☐ Spouse ☐ Dependent ☐ Other	
3.				☐ Primary ☐ Contingent	☐ Spouse ☐ Dependent ☐ Other	

Please check one of the following:

☐ I am not married. If I become married at a future date, I must complete a new Beneficiary Designation form.

☐ I am married. I understand that if I choose to designate a primary death beneficiary other than my spouse, he or she must agree to the designation by signing below. My spouse's signature must be notarized.

Signature of Spouse

Subscribed and sworn to before me this

_____ day of _____, 20____

Date

Notary Public

Privacy Policy.

By executing this form, you acknowledge receipt of the Privacy Policy. You agree to receive future notices of any updates to the Privacy Policy at www.healthcarebank.com, and to review the Privacy Policy no less frequently than annually. See Privacy Policy below.

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FACTS

WHAT DOES HEALTHCARE BANK, A DIVISION OF BELL STATE BANK & TRUST, DO WITH YOUR PERSONAL INFORMATION

Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, shares, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: -Social Security number and account balances -payment history and transaction history -account transactions and checking account information When you are *no longer* our customer, *we* continue to share your information as described in this notice.
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons Healthcare Bank, a division of Bell State Bank & Trust, chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does Healthcare Bank, a division of Bell State Bank & Trust, share?	Can you limit this sharing?
For our everyday business purposes – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	**Yes**	**No**
For our marketing purposes – to offer our products and services to you	**Yes**	**No**
For joint marketing with other financial companies	**No**	**We don't share**
For our affiliates' everyday business purposes – information about your transactions and experiences	**No**	**We don't share**
For our affiliates' everyday business purposes – information about your creditworthiness	**No**	**We don't share**
For nonaffiliates to market to you	**No**	**We don't share**

Questions?	Call toll free 1-866-442-2472 option 1 or go to www.healthcarebank.com

Who we are	
Who is providing this notice?	Healthcare Bank, a division of Bell State Bank & Trust

What we do	
How does Healthcare Bank, a division of Bell State Bank & Trust, protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. We also maintain other physical, electronic and procedural safeguards to protect this information and we limit access to information to those employees for whom access is appropriate.
How does Healthcare Bank, a division of Bell State Bank & Trust, collect my personal information?	We collect your personal information, for example, when you -open an account or apply for a loan -make deposits or withdrawals from your account -use your credit or debit card -seek advice about your investments We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only -sharing for affiliates' everyday business purposes – information about your creditworthiness -affiliates from using your information to market to you -sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing.

Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. -*Our affiliates include financial companies such as State Bankshares, Inc. and nonfinancial companies, such as Discovery Benefits, Inc.*
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. -*Healthcare Bank, a division of Bell State Bank & Trust, does not share with nonaffiliates so they can market to you.*
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. -*Healthcare Bank, a division of Bell State Bank & Trust, doesn't jointly market.*

Terms, Conditions and Signature

Important Information Regarding Patriot Act Requirements

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial organizations to obtain, verify, and record information that identifies each individual who opens an account. What this means for you, when you open an account, you are required to provide your name, residential address, date of birth, and identification number. As part of the ongoing maintenance of your account we may require other information or documentation that allows us to identify you. You understand that your HSA may be closed if additional verification is not possible. Upon such closure, funds deposited in your HSA will be returned to you, less any fees or expenses chargeable against your HSA, or penalties or surrender charges associated with the early withdrawal of any savings instrument or other investment in your HSA account. As custodian, Healthcare Bank, a division of Bell State Bank & Trust shall not be liable for any tax consequences or tax withholdings you may incur as a result of the transfer or distribution of your assets.

Important Information about Electronic Payments

I authorize electronic debit and credit entries, if applicable, to my designated checking or savings account. I also authorize adjustments to these accounts for error corrections. This authorization will remain in effect until the termination of your HSA.

Important Information about your Account

The maximum balance allowed in my Cash Account is based on the designated threshold established by my TPA or me.

Important Information Regarding Death Beneficiary Information

If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary death beneficiary. If any primary or contingent death beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining death beneficiary(ies) shall be increased on a pro rata basis. If more than one primary death beneficiary is designated and no distribution percentages are indicated, the death beneficiaries will be deemed to own equal share percentages in the HSA. Multiple contingent death beneficiaries with no share percentage indicated will also be deemed to share equally. If no primary death beneficiary(ies) survives me, the contingent death beneficiary(ies) shall acquire the designated share of my HSA.

I understand that if I designate my spouse as primary death beneficiary or contingent death beneficiary of the HSA, the dissolution, termination, annulment or other legal termination of my marriage will automatically revoke such designation.

Important Information Regarding My Account Summary

I understand that account summaries are made available electronically and may be viewed at any time by logging into my account at **[Enter TPA Website Address]**. The Healthcare Bank Privacy policy is available online at www.healthcarebank.com. For an additional fee, the HSA Administrator that I identify as my Designated Representative may send paper account summaries and paper copies of the Healthcare Bank Privacy Policy to my address by U.S. mail. I will check the box below if I also wish to receive paper account summaries and paper copies of the Healthcare Bank Privacy Policy by U.S. Mail.

☐ I wish to receive paper account summaries and paper copies of the Healthcare Bank Privacy Policy by U.S. Mail. By electing this option *I acknowledge that an additional fee may apply*. The amount of the fee and frequency of the paper account summaries and paper copies of the Healthcare Bank Privacy Policy are set forth on the attached fee schedule. Paper account summaries are limited to current balances, contributions and distributions.

Important Information Regarding My HSA Investment Account

I understand that once I have accumulated the designated threshold in cash in my HSA as set forth by my TPA or me in the Application, the balance of my account above the designated threshold will automatically be invested in an interest-bearing, FDIC-insured account. For purposes of this enrollment form, "Application" shall mean the 1Cloud by Evolution1® system available through a link provided by my TPA which provides me access to my HSA account information, Investment Account and is used to process my HSA transactions. I may also choose to change my allocation choices and select from the TPA's list of mutual funds for the investment of HSA assets in excess of the designated threshold. The HSA Investment Account is exclusively available online at **[Enter TPA Website Address]**. An email address must be included in enrollment or it will not be available. All investment transactions in the HSA Investment Account will be initiated and conducted electronically. All required disclosures of investment information and trade confirmations will be made electronically, and by opening an HSA Investment Account I consent to the electronic delivery/access of all documents of any issuer whose securities are made available to my HSA, including issuers and securities made available after the date my account is opened.

Important Information Regarding Substitute W-9 Certification

Under penalties of perjury, I certify that: (1) the Social Security Number shown on this form is my correct taxpayer identification number and, (2) 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, and (3) I am a U.S. citizen (including a U.S. resident alien).

Important Information Regarding Fees

Any applicable fees shall be deducted from my account. Fees payable in connection with my HSA are set forth on the attached fee schedule.

Important Information Regarding Custodial and Investment Information

I have read and understand the HSA Custodial Agreement and Disclosure Statement and agree to be bound by those terms and conditions. I understand the eligibility requirements for this HSA and I state that I am responsible for determining whether I qualify to make deposits to this HSA. I am responsible for:

a. determining that I am eligible to make contributions to an HSA for each year I make a contribution;

b. ensuring that all contributions are within the maximum limitations set forth by the tax laws, taking into account my coverage under a high deductible health plan;

c. the tax consequences of any contributions (including rollover contributions) or distributions; and

d. seeking the assistance of a qualified tax or legal professional to address any questions or concerns I may have about eligibility, contribution limitations, or the taxation of contributions or distributions from my HSA.

If I choose to select an investment allocation from the TPA's list of mutual funds, I will be solely responsible for direction of the investment of my HSA. I represent that I will carefully review investment information prior to making investment decisions and that I will seek assistance of a financial professional if I have questions about available investment options or how to select investments for my HSA.

I authorize Healthcare Bank, a division of Bell State Bank & Trust, and its agents to initiate permitted transfers, including contributions, to my HSA, as directed by me or my Designated Representative through the electronic account service features or as otherwise permitted under this HSA. Any such direction shall remain in effect until Healthcare Bank and its agents receive notice of a change to such directions via the electronic account service features or as otherwise permitted under this HSA.

I certify that the information provided by me on this Enrollment Form is accurate, and that I have received a copy of the HSA Custodial Agreement and Disclosure Statement and amendments thereto. I also acknowledge receipt of the Healthcare Bank Privacy Policy. I assume sole responsibility for all consequences found in the Enrollment Form and Custodial Agreement and Disclosure Statement. I understand that I may revoke the HSA on or before the seventh day after the date of establishment. I have not received any tax or legal advice from Healthcare Bank, and I will seek the advice of my own tax or legal professional to ensure my compliance with related laws. I release and agree to hold the Healthcare Bank harmless against any and all claims or losses arising from my actions.

I hereby further agree to designate the TPA to serve as my Designated Representative with respect to my HSA account. By signing below I agree to be bound by the terms and conditions of the separate agreement entitled Designation of Representative by HSA Client and by my signature each party respectively acknowledges his or her understanding and agreement with such terms and conditions.

Signature of HSA Accountholder

Date

Michael S. Solberg

Authorized Signature of Healthcare Bank as Custodian