

## HEALTH SAVINGS ACCOUNT Individual Application

475 - 14<sup>TH</sup> Street, Suite 120, Oakland, California 94612

Toll Free: 1-800-617-4729 Fax 1-877-517-4729

1 INFORMA	TION ABOUT YOU		Plea.	se Print C	Clearly .All fields a	re required.	
Account Holder Name	□ Mr. □ Mrs.	☐ Ms. ☐ Dr.					
		(First Name)		(MI)	(Last Name)		
Mailing Address	(Address)						
Contact Information	(City)	(City) (State) (Zip Code)		ode)			
(Telephone Number) (Emai		(Email Addres	Email Address)				
Social Security Number		Date				r's License/Passport  Government issued identification.	
2 INFORMA		HEALTH INCLIDA	NCE		All fields are requ	uirad	
2 INFORMATION ABOUT YOUR HEALTH II  Name of Health  Plan Carrier		(Ple	Your Annual Deductible (Please check Single or Family Coverage and enter the deductible amount you carry)		uctible y Coverage and	Effective Date of Health Plan	
			☐ Single Coverage ☐ Family Coverage \$				
3 YOUR EMPLOYER INFORMATION  Complete only if you are enrolling through your employer							
Name of Your Employer  Complete only if you are enrolling through your employer  Employer Contact							
	riame or rear Emp.	5,5.	(Name)			(Telephone #)	
4 INFORMATION ABOUT YOUR SPOUSE If Applicable.							
Name			25 7 14		cial Security #	Date of Birth	

Please do not fax! Original signature with payment must be received to avoid delay in processing your application.



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5 INITIAL CONTRIBUTION AND SERVICE FEES. Please Print Clearly .All fields are required						
HSA Contribution	<ul> <li>Minimum \$100.00 initial contribution</li> <li>Maximum Annual Contribution : (2009)</li> <li>Single-\$3,000</li> <li>Family-\$5,950</li> <li>Catch up-\$1,000</li> </ul>			\$		
Account Set-up Charge	■ \$35.00 one-time set-up fee		\$			
Plan Selection	Please choose your preferred pl  ☐ Standard Plan \$8.  ☐ Value Plan \$2.		\$			
Total Amount	■ Amount due to open my account is being:  □ Paid by an attached check to Sterling HSA.  □ Paid on my Employer's List Bill included with this application.			\$		
☐ Male ☐ Fen						
6 ADDITIONAL CONTRIBUTIONS.  Complete only if you, the subscriber, will be making additional regular contributions besides your employer's contributions						
Additional Contribution  Additional Contribution  \$		<u> </u>		d of payment: Check Payroll		
7 DEBIT CARD REQUEST. Opt						
	By checking the box, please order a Debit Card in my name. I understand that debit cards can only be issued in my name and two cards will be mailed to my address within 10 business days from the date of processing this application. Cards must be activated for use. A minimum of \$50.00 must be kept in my SterlingHSA account at all times.					
8 BROKER AGENT INFORMATION. Do not complete if enrolling through your Employer.						
			Phone Number	:		
(Name of Broker)		(Broker License Number)	Email Address:			
9 ACKNOWLED	GEMENT / CUSTODIAL AC	REFEMENT	Require	ed		



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This Subscriber Application Form, when signed by me and accepted by St Sterling Health Services, Inc. Custodial Agreement and my agreement to be be that may be amended from time to time. I further agree that I will be bound by any by Sterling HSA. By signing this Subscriber Application Form, I consent to the sharing among Sterling HSA's various affiliates. I acknowledge that summary information regar at "www.SterlingHSA.com"	bound by the terms and conditions of the Custodial Agreement conditions or limitations regarding my Custodial Account established of financial and other information between me and Sterling HSA and
(Account Holder's Signature)	(Date)