

HSA Application & Salary Reduction Agreement

This Salary Reduction Agreement (SRA) authorizes your employer to reduce your salary by the indicated amount shown below for the exclusive purpose of facilitating a contribution to your Health Savings Account through your Cafeteria Plan. Do Not Send Contributions With This Form.

By completing this agreement, you are indicating that as of the effective date of your contribution election, you are an "Eligible Individual" as defined in the adoption agreement and authorize your employer to facilitate your monthly contributions to your HSA on your behalf. Please fill out the form below and fax it to EBD at 501-683-0983 or mail it to P.O. Box 15610, Little Rock, AR 72231.

Instructions

*Are you a current HSA Account Holder?

Yes Fill out only your name in section 1 and proceed to sections 2 through 5.

No Complete ALL required information, marked with an asterisk (*) on both sides and sign the form. Look in the mail for your HSA Welcome Letter, which includes additional HSA services.

1 Account Holder Information (Please Print)

*Required Field

*Name: (First) _____ (MI) _____ (Last) _____

*Preferred Mailing Address: Home Address Mailing Address (if different than Home Address)

*Home Address: _____ Mailing Address: _____

City: _____ City: _____

State: _____ Zip: _____ State: _____ Zip: _____

*Preferred Phone Number: Home Work

*Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

If we need to reach you what is the best time to call: _____ AM PM

*Email Address: _____

*Date of Birth: _____ *Social Security Number: _____

*Driver's License Number: _____ *Mother's Maiden Name (security): _____

*School / Agency: _____

2 Primary Beneficiary

*Name: (First) _____ (MI) _____ (Last) _____

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, all non allocated funds (if any) in your account will be distributed to your Contingent Beneficiary (To add/edit/change Contingent Beneficiaries, login into your account at hsatoday.com) In the event that no beneficiary can be located, your account balance (if any) will be distributed to your estate.

3 HSA Contribution Election

I elect a monthly or pay period contribution of \$ _____ to my HSA effective _____

Amount Date

Contributions to a health savings account are qualified only for those members enrolled in the ARBenefits Bronze plan. The annual contribution for single coverage is limited to \$3,100 and for family coverage is limited to \$6,250 for Tax Year 2012. Your enrollment information will be verified with ARBenefits.

HSA Application & Salary Reduction Agreement cont.

4 mySourceCard® Debit Card

I hereby request a mySourceCard™ MasterCard® debit card as an alternate distribution method from my HSA account. (See Article IV of the Custodial Account Agreement for terms of usage.) Print exactly as you would like it to appear on your card. 21 characters maximum, including spaces. If additional cards are needed, please include a separate sheet(s).

Name on 1st Card:

Name on 2nd Card:

5 Adoption Agreement / Employee Signature

As of the effective date of my HSA Contribution Election, I certify that I am an “Eligible Individual” as defined by the Code and do hereby elect a Health Savings Account in accordance with Section 223 and Section 125 of the Internal Revenue Code. I understand this request will not be processed until all paperwork is completed, accepted and approved by my employer. I further understand that I am responsible for all contributions made to my HSA and that DataPath Administrative Services, Inc. is facilitating but not initiating the contribution. If the account is closed at anytime, there will be a \$25 closing fee.

This application is for the establishment of my individually owned Health Saving Account at the custodian displayed below. 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 Account Agreement, HSA Terms and Conditions Statement and the HSA Disclosure Statement. I also acknowledge that the Plan Service Provider (PSP) indicated on the bottom of this form is authorized to perform transactions on my account and all such transactions initiated by the PSP should be treated as if initiated directly by me, the Account Holder. I am currently, or will be upon the date of my first contribution, an eligible individual as described in the Custodial Account Agreement. I understand that maintaining my eligibility is my responsibility and that the custodian will assume that all contributions are made while I am eligible to do so. I am currently, or will be upon the date of my first contribution, covered by a High Deductible Health Plan that meets the qualifications detailed in the Custodial Account Agreement.

*Signature of Account Holder: _____ Date: _____

Employer Signature

The employee’s election of the Health Savings Account Contribution is accepted as of the date shown below.

*Authorized Signature: _____ Date: _____

Custodian

National Advisors Trust Company, FSB
10881 Lowell Avenue, Suite 100 • Overland Park, KS 66210

Plan Service Provider

DataPath Administrative Services, Inc.
Serial Number: 666576474227
1601 Westpark Drive, Suite 9 • Little Rock, AR 72204
Web: www.idpas.com • Email: info@idpas.com
Phone: (877) 685-0655 • Fax: (888) 472-6777
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