



If you have any questions about HSAs or completing this form, please contact SuperiorUSA at (877) 529-2477.

Part I - Accountholder Profile Information			
*Consumer Name (First, MI, Last)		*Employer Name (If sponsored by an employer plan)	
*Birth Date (MM/DD/YYYY)	*Social Security Number	*Home Phone	*Mobile Phone
*Physical Street Address (U.S. address required to open an HSA)			
*City		*State	*Zip
Alternate Mailing Street Address or PO Box			
City		State	Zip
*Email Address		*Date of Birth	
*Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unspecified		*Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single	
*Mother's Maiden Name			
*Hire Date	*Hours Worked per Week	*Payroll Frequency	

Part II - Authorization and Eligibility Certification		
<p>When opening an HSA with SuperiorUSA, I understand and agree to the following:</p> <ul style="list-style-type: none"> • I am at least 18 years old and cannot be claimed as a dependent on someone else's tax return. • I am covered under a high deductible health plan (HDHP). • I am not enrolled in Medicare. • I do not have any other non-qualified health coverage. • I do not have a flexible spending account (FSA) to pay for medical expenses incurred before my medical plan deductible is met, unless it is limited to pay for dental and vision expenses only. • My spouse, if applicable, does not have a flexible spending account (FSA) to pay for medical expenses before their medical plan deductible is met, unless it is limited to pay for dental and vision expenses only. <p>As a follow-up to this application, you will need to login to the HSA website to accept your terms and conditions.</p>		
*Signature	*Print Name	*Date

Part III - Election for Payroll Deduction

(Complete this section if you are enrolling through your employer's benefit offering)

I authorize my employer to deduct my HSA contributions from my payroll, and forward them to my HSA.

My health plan coverage Type: Single Family

Note – The HSA has a maximum annual contribution limit that is determined by your health insurance coverage (self-only/family). Your employer may choose to contribute to your HSA, which will count towards to your maximum contribution allowed. Your health plan eligibility determines the effective date of your HSA. If you are covered on December 1, you're considered eligible for the entire year and not required to pro-rate your contributions. If you cease to be an eligible individual during the next calendar year, any contributions over the prorated amount may be an excess contribution. You are solely responsible for determining whether contributions to your 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. For additional information regarding eligible and contribution limits please go to: www.irs.gov.

2020 Annual Contribution Limit

Health Plan Coverage Level	*Annual Contribution Limit	Per Month
Self-Only	\$3,550	\$295.83
Family	\$7,100	\$591.67

2021 Annual Contribution Limit

Health Plan Coverage Level	*Annual Contribution Limit	Per Month
Self-Only	\$3,600	\$300
Family	\$7,200	\$600

*Age 55+ eligible for an additional catch-up contribution of \$1,000

Your Personal Contribution Election

Annual Maximum Contribution (plus catch up if eligible)	Minus (-)	Total Employer Annual Contribution	Equals (=)	Your Eligible Annual Contribution	Divide (/)	Number of Payrolls per Year	Equals =	Your Maximum Per Pay Period Payroll Deduction
\$ _____		\$ _____		\$ _____		_____		\$ _____

Please withhold \$ _____ from my payroll and apply to my SuperiorUSA HSA.

Part IV - Debit Card

A debit card will automatically be issued to you to use to make medically qualified purchases from your HSA account. You should retain receipts and/or documentation for tax purposes.

Part V - Bank Account and Reimbursement Method

When I am not using my debit card and request a distribution through the HSA website, then I select the method below to automatically to receive my HSA distributions.

Paper Check – I wish to have a paper check mailed to me. [I understand there may be a per check fee of \$3.00].

OR

FREE Direct Deposit – I wish to have distributions automatically deposited into my personal bank account and will complete the Direct Deposit Setup below. This personal bank account can also be utilized to make a post-tax contribution to your HSA from the HSA website and the HSA mobile application.

Enter your personal bank account information if Direct Deposit selected above.

*Bank Name

*Address

*City

*State

*Zip

*Account Type

Checking Savings

*Routing #

*Account #

JON SMITH 1234 8th ST. S. FARGO, ND 58102 1200

DATE _____

PAY TO THE ORDER OF _____ \$ _____

MEMO _____

⑆0 2345678⑆ ⑆68590134⑆ 1200

Routing # Account #

Next Steps:

1. Return completed form to your employer
2. Verification of your identity is required for opening an HSA and may result in needing to supply additional information. If this applies to me, then I will be notified by SuperiorUSA and/or your employer on how to proceed.
3. Log into the HSA Portal to begin to monitor your account.

Health Savings Account Beneficiary Form

Use this form to request a beneficiary for your HSA. If you want to designate a primary beneficiary other than your spouse, and you live in a community property state (for example AK, AZ, CA, ID, LA, NV, NM, TX, WA or WI), your spouse must agree in writing to your designation, and you must submit a physical copy of this form. Designations are effective upon receipt by SuperiorUSA and, unless otherwise specified, cancel all previous HSA beneficiary designations on file.

1. Complete all sections of this form.
2. Email, mail or fax completed form to:

Email: flexservices@superiorusa.com

Address: SuperiorUSA, 525 Lake Ave. South, Suite 410, Duluth, MN 55802

Fax: (218) 725-9161

***Required Fields**

Part I Consumer Information			
*Consumer Name (First, MI, Last)		*Employer Name (If sponsored by an employer plan)	
*Birth Date (MM/DD/YYYY)	*Social Security Number	*Day Telephone	
*Address			
*City	*State	*Zip	

Part II Designation of Beneficiary(ies)

- If neither the primary nor contingent beneficiary is indicated, the individual or entity will be deemed to be the primary beneficiary.
- If any beneficiary dies before me, his or her interest shall terminate completely, and the percentage of any remaining death beneficiary(ies) shall be increased on a pro rata basis.
- If more than one primary beneficiary is designated and no distribution percentages are indicated, the death beneficiaries will be deemed to own equal share percentages in the HAS.
- 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.
- If you designate your spouse as primary death beneficiary or contingent death beneficiary of the HSA, the dissolution, termination, annulment or other legal termination of your marriage will automatically revoke such designation.

Beneficiary #1

Share percentages must equal 100% for primary and 100% for contingent if adding multiple beneficiaries.

* Full Name (or Trust and Trustee Name)		<input type="checkbox"/> Primary	*Share %
		<input type="checkbox"/> Contingent	
* Birth Date (MM/DD/YYYY) (or Trust Creation Date)	*SSN (or Trust TIN)	*Relationship	
*Address			
*City	*State	*Zip	

Beneficiary #2

Share percentages must equal 100% for primary and 100% for contingent if adding multiple beneficiaries.

* Name (First, MI, Last)		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	*Share %
* Birth Date (MM/DD/YYYY)	*SSN	*Relationship	
*Address			
*City	*State	*Zip	

Beneficiary #3

Share percentages must equal 100% for primary and 100% for contingent if adding multiple beneficiaries.

* Name (First, MI, Last)		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	*Share %
* Birth Date (MM/DD/YYYY)	*SSN	*Relationship	
*Address			
*City	*State	*Zip	

Part III Marital Status / Consumer Authorization

I Am Not Married – I understand that if I become married in the future, I must complete a new HSA Beneficiary Form.

I Am Married – I understand that if I choose to designate a primary beneficiary other than my spouse, my spouse must sign below. **

**I am the spouse of the above-named HSA Account Holder. I acknowledge that I have received a fair and reasonable disclosure of my spouse's property and financial obligations. Due to the important tax consequences of giving up my interest in this HSA, I have been advised to see a tax professional.

**Spouse Signature	*Date
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Consumer Consent

I hereby give the HSA Beneficiary any interest I have in the funds or property deposited in this HSA and consent to the beneficiary designation(s) indicated above. I assume full responsibility for any adverse consequences that may result. I acknowledge that this form may be electronically signed (if no spouse signature is required) and I agree that the electronic signature appearing on this document is the same as handwritten signatures for the purpose of validity, enforceability and admissibility.

*Consumer Signature	*Date
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Health Savings Account Information Authorization Form

Use this form to authorize another individual access to information regarding your HSA. If you have any questions about HSAs or completing this form, please contact SuperiorUSA at (877) 529-2477.

Process:

1. Email, mail or fax completed form to:
 - Email:** flexservices@superiorusa.com
 - Address:** SuperiorUSA, 525 Lake Ave. South, Suite 410, Duluth, MN 55802
 - Fax:** (218) 725-9161

*Required Fields

Part I Profile Information			
*Consumer Name (First, MI, Last)		*Employer Name (If sponsored by an employer plan)	
*Birth Date (MM/DD/YYYY)	*Social Security Number	*Day Telephone	
*Address			
*City		*State	*Zip
Email Address			

Part II Authorized Individual Information – I authorize HSA Administrator’s customer service representatives to provide information regarding my HSA, including but not limited to the balance and transaction history, to the individual named below.

I understand and agree that:

- the individual named below will **not** be authorized to perform my account maintenance; and
- this authorization pertains to information obtained from customer service only; and
- I am the sole individual authorized to access and maintain my account online.

*Authorized Individual Name (First, MI, Last)		
*Address		
*State	*State	*Zip
*Phone Number		

Part IV Consumer Signature

I certify that I am the HSA Accountholder or an individual authorized to execute this transaction. I have read and understand the instructions and any rules or conditions relating to this transaction. I assume full responsibility for this transaction and will not hold SuperiorUSA or WEX Inc. liable for any adverse consequences that may result. I have not received tax or legal advice from SuperiorUSA or WEX Inc., and, if necessary, will seek the advice of a tax or legal professional to ensure my compliance with related laws. All information provided by me is true and correct and may be relied upon by SuperiorUSA. I acknowledge that changes specified on this form shall become effective as soon as administratively feasible upon the receipt of this form. I acknowledge that this form may be electronically signed, and I agree that the electronic signature(s) appearing on this document are the same as handwritten signatures for the purpose of validity, enforceability, and admissibility.

*Consumer Signature	*Date
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