Health Savings Account and Membership Application

KEMBA FINANCIAL CREDIT UNION
A better way to bank

☐ **I want to belong!** *(please complete the following information)* ☐ I am already a member. Account Number _____

To join the Credit Union you need to meet just one of the following criteria:

(a) ☐ Select Employee Group or Organization _____ (b) ☐ Family Member _____
Name of Employer or Organization — Name of Employee or Organization

(c) ☐ I live, work, worship, or attend school in: *(please circle one)*

Franklin County Fairfield County Delaware County Licking County Logan County Madison County Union County Sylvania Township

How did you hear about KEMBA? _____ 544

PRIMARY MEMBER INFORMATION *(select account type)* ☐ Individual ☐ Family

First Name, Middle Initial, Last Name			Mother's Maiden Name	
Social Security Number	Date of Birth	Driver's License Number and State	Driver's License Issue date	Driver's License Expiration date
Home Address *(required)*			City, State, Zip Code	
Mailing Address *(if different from home address)*			City, State, Zip Code	
Home Phone ( )	Cell Phone ( )		Email Address ☐ Yes! I want eStatements.	

☐ YES ☐ NO KEMBA's mission is to enrich the financial lives of its members. I agree to receive auto-dialed and/or pre-recorded calls from KEMBA about products and services, that may be of benefit to me, at the number(s) provided above, including any wireless number(s). I understand that consent is not a condition of membership and that I may opt out from these informational calls at any time.

Present Employer	Length of Employment and Position	Gross Monthly Income $
Address of Employer	City, State, Zip Code / Work Phone ( )	Other Income and Source* $

*Alimony, child support, or maintenance payments are optional and need not be revealed if the applicant does not choose to rely on such income in applying for credit.

HSA Debit Card

☑ **Health Savings Account w/ Debit Card** Additional Authorized Signers:

1) _____
Printed Name — Address — Birthdate — SSN — Signature of Additional Signer

2) _____
Printed Name — Address — Birthdate — SSN — Signature of Additional Signer

3) _____
Printed Name — Address — Birthdate — SSN — Signature of Additional Signer

To add additional authorized signer, please contact a KEMBA representative.

ESTABLISH PAYROLL DEDUCTION OR DIRECT DEPOSIT

1. How are you paid? ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other
2. Do you want your entire check to go to KEMBA? ☐ Yes ☐ No If "No," how much would you like sent to KEMBA? $ _____
3. How do you want your check distributed? Enter dollar amount to go into each account. Write "NET" if you want the balance of your deduction to go into that account.

Health Savings Account $	Checking Account $	Savings Account $	Other (please describe) $

LEARN MORE ABOUT KEMBA

Savings and Deposit Products
☑ Membership Share Savings Account ☐ Checking Account w/ Debit Card ☐ Money Market Account ☐ Certificate of Deposit

I want KEMBA to authorize and pay my Debit Card courtesy pay transactions. ☐ Yes ☐ No

I want KEMBA to authorize and pay my check and ACH courtesy pay transactions. ☐ Yes ☐ No

Loan Products
☐ Auto Loan ☐ Mortgage Loan ☐ Home Equity Loan ☐ Student Loan ☐ I would like to transfer a loan *(please contact me)*
☐ Visa® Platinum Rewards Credit Card ☐ MasterCard® Platinum Rewards Credit Card ☐ Other _____

AUTHORIZATION (SIGNATURES REQUIRED)

By signing below, I/we agree to the terms and conditions of the Membership and Account Agreement and to any amendments the Credit Union makes from time to time. I/We acknowledge receipt of a copy of the Agreement and Disclosure applicable to the accounts and services requested, or receipt of a copy within an appropriate amount of time after requesting services remotely.

IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING A NEW ACCOUNT: To help the government fight the funding of terrorism and money laundering activities, federal law requires that all financial institutions obtain, verify, and record information that identifies each person who opens an account. What this means to you: When you open an account, we ask for your name, address, date of birth, and other information that will allow us to identify you. We may ask to see your driver's license or other identifying documents.

NOTICE TO ALL OHIO LAWS AGAINST DISCRIMINATION REQUIRE THAT ALL CREDITORS MAKE CREDIT EQUALLY AVAILABLE TO ALL CREDITWORTHY CUSTOMERS AND THAT CREDIT REPORTING AGENCIES MAINTAIN SEPARATE CREDIT HISTORIES ON EACH INDIVIDUAL UPON REQUEST. THE OHIO CIVIL RIGHTS COMMISSION ADMINISTERS COMPLIANCE WITH THIS ACT. I certify that all information submitted is true and complete. I authorize KEMBA Financial Credit Union to verify the information contained in this statement and to obtain further information concerning my credit standing.

TIN CERTIFICATE BACKUP WITHHOLDING INFORMATION Instructions: Cross through any statement that does not apply.
Under penalties of perjury, I certify that:

1. The number shown on this form is my correct Social Security number (SSN) or Taxpayer Identification Number (TIN); 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 IRS that I am subject to backup withholding as a result of a failure to report 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 or a U.S. permanent resident alien; and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

X _____ _____
Signature of Applicant (Primary Member) Date

PRIMARY MEMBER INFORMATION

I designate that upon my death, the assets in this account be paid to the beneficiaries named below. The interest of any beneficiary that predeceases me terminates completely, and the percentage share of any remaining beneficiaries will be increased on a pro rata basis. If no beneficiaries are named, my estate will be my beneficiary.

☐ I elect not to designate beneficiaries at this time and understand that I may designate beneficiaries at a later date.

PRIMARY BENEFICIARIES *(the total percentage designated must equal 100%)*

Name _____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID (SSN/TIN) _____ Percent Designated _____

CONTINGENT BENEFICIARIES *(The total percentage designated must equal 100%. The balance in the account will be payable to these beneficiaries if all primary beneficiaries have predeceased the HSA owner.)*

Name _____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID (SSN/TIN) _____ Percent Designated _____

☐ Check here if additional beneficiaries are listed on an attached addendum. Total number of addendums attached to this HSA _____

SPOUSAL CONSENT

Spousal consent should be considered if either the trust or the residence of the HSA owner is located in a community or marital property state.

CURRENT MARITAL STATUS

☐ **I Am Not Married -** I understand that if I become married in the future, I should review the requirements for spousal consent.

☐ **I Am Married -** I understand that if I choose to designate a primary beneficiary other than or in addition to my spouse, my spouse should sign below.

CONSENT OF SPOUSE

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

I hereby give the HSA owner my interest in the assets or property deposited in this HSA and consent to the beneficiary designation indicated above. I assume full responsibility for any adverse consequences that may result.

X _____ _____
Signature of Spouse — Date *(mm/dd/yyyy)*

X _____ _____
Signature of Witness — Date *(mm/dd/yyyy)*

SIGNATURES

Important: *Please read before signing.*

I understand the eligibility requirements for the type of HSA deposit I am making, and I state that I do qualify to make the deposit. I have received a copy of the Health Account Application, the 5305-C Custodial Account Agreement, and the Disclosure Statement. I agree to be bound by those terms and conditions.

I assume complete responsibility for

- determining that I am eligible for an HSA each year I make a contribution,
- ensuring that all contributions I make are within the limits set forth by the tax laws, and
- the tax consequences of any contributions (including rollover contributions) and distributions.

X _____ _____
Signature of HSA Owner — Date *(mm/dd/yyyy)*

X _____ _____
Signature of Witness — Date *(mm/dd/yyyy)*

X _____ _____
Signature of Custodian — Date *(mm/dd/yyyy)*