U₁ Health Savings Account Enrollment Materials

As part of your High Deductible Health Plan (HDHP) and your Health Savings Account (HSA) benefit, your employer has selected **FlexBank/Navia Benefit Solutions** as an HSA administrator. Your HSA is designed to help you save and pay for health care expenses on a tax-free basis and provide resources to answer questions.

HSA Application Checklist

Universal 1 Credit Union (u1cu.org) will be the financial institution providing your HSA. Please complete the checklist below and return it to your employer's Benefits Administrator to open your account.

- ____ Health Savings Account Application
- ____ FlexBank/Navia Benefit Solutions Administrative Services Agreement
- _____ \$5 Membership Deposit (Check or Origination Agreement ACH Debit Form)

Additional Contributions

If you are interested in contributing to your HSA on a pre-tax basis, complete the Contribution Form in this HSA packet and forward to your Benefits Administrator. You will receive an email confirmation whenever your employer contributes to your account or a deposit has been made from a payroll deduction.



U1 Health Savings Account

Universal 1 welcomes you! We know health funds are crucial to well-being and do our best to provide an HSA worthy of your membership.

- + Highly competitive interest rate
- + No monthly fee
- + Free HSA debit card
- + Online Banking & Monthly E-Statements
- + Investment options on balances \$1,000+



FlexBank/Navia Benefits

1250 W Dorothy Lane Suite 107 Dayton, OH 45409

Phone888.677.8373EmailDAYHSA@FlexBank.netWebwww.FlexBank.net

U Health Savings Account Application

Federal Law requires Universal 1 Credit Union to obtain, verify and record identity. When opening an account, you will be asked for information that confirms identity such as a copy of your driver's license or other federal or state government ID. Thank you in advance for your cooperation.

Owner Information

First Name	MI	Last Name			Account #		SSN	
Street Address			City State Zip					Zip
Home Phone		Work Phone			Em	ail		
Employer Name		Address		City			State	Zip
Health Insurance Coverage] Single	e □ Family Form □ No	n Purpose	: DN	New HSA 🛛 C	hanges t	o existing	HSA

Membership Application (Complete if you are not a U1 member)

ID Type (License, etc.)	ID #	Issuing State	Issue Date	Expiration Date	Birthdate

Certification Instructions. Check the box for item 2 if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. By checking this box, this serves to strike out the language related to underreporting. Complete a W-8 BEN if you are not a U.S. person. If a W-8 is completed, your signature does not serve to certify this section. Exempt Codes

TIN Certification and Backup Withholding Information - Under penalties of perjury, I certify that:

- (1) The number shown on this form is my correct Taxpayer Identification Number (TIN) or I am waiting for a number to be issued, 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 or other U.S. person. For federal tax purposes, you are considered a U.S. person if you are: an individual who is a U.S. citizen or U.S. resident alien; partnership, corporation, company, or association created or organized in the United States or under the laws of the United States; estate (other than foreign); or domestic trust (defined in Regulations Section 301.7701-7).

(4) The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Primary Beneficiary Designation

□ I designate that upon my death, the assets in this account be paid to the beneficiary 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. I understand that additional beneficiaries may be added, and I should contact U1 Member Support to do so.

□ I elect not to designate beneficiaries and understand I may designate at a later date. If none are named, my estate will be my beneficiary.

Name	Birt	hdate	Relationship		Tax ID (SSN/TIN)	
Street Address			City	Sta	ite	Zip

Spousal Consent & Status (Required if residing in a community or marital property state)

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.

- □ I am not married I understand that if I become married, I should review the requirements for spousal consent.
- □ I am married I understand if I choose a primary beneficiary other than or in addition to my spouse, my spouse should sign below.

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. Additionally, 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.

Spouse Signature

Date

Witness Signature

Date

Authorized Signer (Optional)

Since regulations require one individual own an HSA, the account holder may want another authorized signer to write checks or use debit card. By designating an authorized signer on your account, you authorize the person designated above as "Authorized Signer" to transact business with and give instructions to Universal 1 Credit Union (U1) regarding your health savings account; make deposits or withdrawals by any means acceptable to U1, including paper and electronic methods such as ACH and Internet-generated transactions; receive and have access to account information, including account balances and transactions; endorse any instruments such as checks, orders or other documents for the payment of funds; and to otherwise serve as agent for your U1 health savings account.

You specifically authorize U1, as custodian of your HSA, to rely upon this authorization and designation until such time, if any, that U1 receives a written revocation of this authorization, and has had a reasonable time to act upon the revocation. You understand that you are responsible for ensuring that your authorized signer reads and understands U1 Account Disclosures which have been provided to you. You hold harmless and indemnify U1 against any claims against or losses U1 may suffer arising out of U1's reliance on this authorization, and release U1 from any liability arising from such reliance, unless otherwise prohibited by law. You understand that you bear sole responsibility for any tax consequences that result from any actions taken by the authorized signer regarding your account.

No present or future ownership or right of survivorship is given to the authorized signer by this authorization. Upon notice to U1 of your death, this authorization terminates, and rights to funds in your account will be transferred to your beneficiaries. If no beneficiary is named, your account balance will be payable to your estate.

I (account holder), as named above, designate the following individual as an additional authorized signer on my Health Savings Account.

First Name	MI	Last Name		S	SSN	Birt	hdate		Home Phone
Street	Addre	SS			City		State		Zip
ID Type (License, etc.)		ID #	lssu	ing State	Issue Da	ate	Expiration [Date	Birthdate
Issue a Debit Card to my authoriz	ed sig	ner for my HSA Account		□ Yes	□ No				

Account Holder Signature

Date

Authorized Signer

Date

Acknowledgements & Signatures

I understand the eligibility requirements for this 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 Savings Account Application, the 5305-C Custodial Account Agreement, and the Disclosure Statement. I understand that the terms and conditions that apply to this HSA are contained in this Application and the HSA Custodial Account Agreement. I agree to be bound by those terms and conditions.

I assume complete responsibility for: 1) Determining that I am eligible for an HSA each year I make a contribution; 2) Ensuring that all HSA contributions I make are within the limits set forth by the tax laws; and 3) The tax consequences of any contributions (including rollover contributions) and distributions. I also understand that IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Credit Report Authorization: By signing below you authorize Universal 1 Credit Union, Inc. (U1) to check your employment and credit history and to obtain credit reports in connection with any request for membership or credit, including any update, increase, renewal, extension or collection of credit you receive. If you request, U1 will tell you the name and address of any credit bureau from which it received a credit report on you. The credit union will rely on information you have provided. By signing below you affirm that all information on this document or that has been provided elsewhere is correct.

Account and/or Account Service Requests: By signing below you acknowledge that you have received and agree to the terms and conditions contained in the <u>Membership and Account Agreement</u>, <u>Truth-in-Savings Disclosure</u>, <u>Funds Availability Policy Disclosure</u>, <u>Electronic Fund</u>, <u>Transfers Agreement and Disclosure</u>, <u>Privacy Notice</u> and to any amendments to these documents that U1 may make from time to time.

HSA Owner Signature

Date



Date

Mail, email or fax form to 1 River Park Dr, Dayton, OH 45409 | hsa@u1cu.org | Fax 800.436.3212 Universal 1 Credit Union | u1cu.org | 937.225.6800

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Universal 1 Credit Union Origination Agreement ACH Debit

Complete to allow U1 to initiate debit(s) from an existing account to a U1 account.

Full Name	Address
City, State & Zip	Daytime Phone Number(s)

Withdraw Account

Financial Institution	Routing #	Account #	Amount			
			\$5.00			
Account Checking (27) Savings (37)						
Frequency X One Time Payment Date (At least 5 business days from current date for processing)						

Deposit Account (U1 Office Use Only)

L	J1 Account #	Suffix

*Account number and suffix added upon form receipt and processing of share account.

By signing below

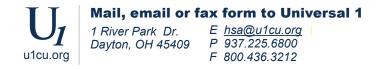
I hereby authorize Universal 1 Credit Union to initiate debit entries to my account indicated above and the Credit Union/Bank indicated above. This authorization is in effect until I notify Universal 1 Credit Union in writing that I want this payment stopped. The request must include my name, credit union account number, company, amount, and the date that I want the payment stopped (this must be at least 10 business days in the future).

Signature

Date

Form Taken By

Dept/Divison



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FlexBank/Navia Benefit Solutions Administrative Services Agreement

By signing this form I understand that the following administrative services for my Universal 1 Health Savings Account ("HSA") are provided to me by FlexBank/Navia Benefit Solutions Administrative Services provided by FlexBank/Navia Benefit Solutions include enrollment assistance, access to the toll-free tax assistance help-line to answer any questions concerning Health Savings Accounts, qualified medical expenses, or other distributions.

I understand that I, and not FlexBank/Navia Benefit Solutions, am personally responsible for all aspects of my HSA. I hereby appoint and authorize FlexBank/Navia Benefit Solutions as my designated agent to interact with Universal 1 as may be required in the administration of my HSA. I hereby specifically consent to and permit Universal 1 to provide my account number, account information and other non-public information concerning my HSA to FlexBank/Navia Benefit Solutions and authorize Universal 1 to interact with FlexBank/Navia Benefit Solutions as may be required or appropriate in the administration of my HSA. This appointment of FlexBank/Navia Benefit Solutions as my designated agent is effective as of the date shown on this application or until revoked by me in writing. I have read and consent and agree to the terms of the FlexBank/Navia Benefit Solutions Administrative Agreement described above.

Signature

Date

HSA DIRECT TRANSFER INSTRUCTIONS (FORM 2625H)

Please Print or Type

TO:

Current HSA, MSA, or IRA Fiduciary

Account Number at Current Institution

Mailing Address of Current HSA, MSA, or IRA Fiduciary

Please liquidate and transfer the amount indicated below from the Health Savings Account (HSA), Archer Medical Savings Account (MSA), or traditional IRA you are maintaining on my behalf to the HSA I have established at my credit union (named in the Identifying Information section of this form). Make the check payable as follows: Name of Credit Union, F/B/O HSA Owner's Name. Note on the check that It is for deposit to account number ________, at the credit union. Attach the check to a copy of this form and send it to the credit union can only accept a check to implement this transfer, so please don't send it in any other form.

Type of Transfer

□ HSA to HSA □ Archer MSA to HSA

Traditional IRA to HSA

IDENTIFYING INFORMATION

Account Owner's	Name	(First,	Initial,	Last)	
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Social Security Number HSA Suffix

CUID (Credit union will complete.)

City, State, ZIP

Credit Union Name

. .

Phone Number

Contact Person at Credit Union

Credit Union Mailing Address

AMOUNT AND TIMING OF TRANSFER

Liquidate the current investment and transfer the proceeds as follows. Check one box in each column. Amount to transfer: Make this transfer:

□ 1. \$_

🛛 1. On ___

2. The entire amount in my account and close my account. 2. Immediately.

3. At maturity of the investment.

Date (MM/DD/YYYY)

CREDIT UNION'S SIGNATURE

The credit union named above agrees to act as successor trustee or custodian and accept the transfer described above for deposit to the HSA established on behalf of the owner named above.

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Credit Union Representative's Signature

Date (MM/DD/YYYY)

ACCOUNT OWNER'S SIGNATURE

I have established an HSA with the credit union named above. I authorize the current fiduciary of my HSA, MSA, or traditional IRA to liquidate the above described portion of my interest in the plan and send the proceeds to my credit union as directed on this form. (The HSA owner should check with the fiduciary that currently has the funds to determine whether a signature guarantee is required.)

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Account Owner's Signature

Date (MM/DD/YYYY)

Stock # 26638 2625H (Doc Code 25) (Rev. 12/2009)