

**Health Savings Account**

**Fayetteville Bank**

MEMBER FDIC  
P.O. BOX 9  
FAYETTEVILLE, TX 78940  
(979)378-4261

**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 all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: When you open an account, we will ask for your name, address, date of birth, and other information that will allow us to identify you.

**TYPE OF ACCOUNT**

**OWNERSHIP OF ACCOUNT**

**DATE:** \_\_\_\_\_

\_\_\_\_ **HSA Individual**

All Health Savings  
and Individual Retirement  
accounts are individually owned

**SOURCE OF DEPOSIT:**

\_\_\_\_ **HSA Family**

\_\_\_\_ CASH \_\_\_\_ CHECKS

**OPENING DEPOSIT:**

\$ \_\_\_\_\_

**\*\*\*\*\*TWO FORMS OF I.D. REQUIRED WHEN OPENING ACCOUNT\*\*\*\*\***

**PRIMARY OWNER INFORMATION**

**PRIMARY BENEFICIARY INFORMATION**

NAME: \_\_\_\_\_

NAME: \_\_\_\_\_

\*PHYSICAL ADDRESS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\*MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_

PHONE: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

RELATIONSHIP TO ACCOUNT OWNER: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

**CONTINGENT BENEFICIARY INFORMATION**

DATE OF BIRTH: \_\_\_\_\_

NAME: \_\_\_\_\_

SOCIAL SECURITY#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DRIVER'S LICENSE: \_\_\_\_\_

PHONE: \_\_\_\_\_

STATE OF DRIVER'S LICENSE: \_\_\_\_\_

RELATIONSHIP TO ACCOUNT OWNER: \_\_\_\_\_

LICENSE EXPIRATION DATE: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

PLACE OF BIRTH: \_\_\_\_\_

MOTHER'S MAIDEN NAME: \_\_\_\_\_

UNITED STATES CITIZEN? Yes No

IF NO, WHAT COUNTRY? \_\_\_\_\_

**EMPLOYER INFORMATION**

NAME: \_\_\_\_\_

YEARS EMPLOYED: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

One MasterCard Debit Card will be ordered for the account owner.

**FOR FAMILY COVERAGE:** Will another "HDHP covered" adult be an additional authorized (convenience) signer on the account? **YES NO**

If yes, two forms of identification will also be required.

I certify that everything I have stated in this application and on any attachments is correct. You may keep this application whether or not it is approved. By signing below I authorize you to check my credit account and employment history and/or have a credit-reporting agency prepare a credit report on me. I understand that it is my responsibility to confirm that I am qualified to make contributions to a Health Savings Account.

**X** \_\_\_\_\_  
Signature of Account Owner