

Health Savings Account (HSA) Enrollment Form for Employees

Personal Information				
Last Name	First Name	M.I.	Date of Birth	Social Security # (XXX-XX-XXXX)
Street Address		City	State	Zip
E-mail Address	Country of Citizenship	Phone (XXX-XXX-XXXX)	Alternate Phone (XXX-XXX-XXXX & ext.)	
Name of Employer			Employer Tax ID (Required)	
Health Insurance Carrier/Insurance Provider			Coverage for: Individual <input type="checkbox"/> Family <input type="checkbox"/>	
Account Setup				
<p>A monthly administrative fee will automatically be deducted from your HSA. The standard fee is \$3.25 unless otherwise specified by your insurance carrier or employer. Note: Scheduled pre-tax payroll deductions must be established through your employer. Any future changes must also be done through your employer. Please contact your employer for details.</p>				
<p>Please do not send funds with this form. If you would like to deposit funds, you may access the appropriate forms at www.wellsfargo.com/hsa. To make a contribution outside of a payroll deduction, complete the Contribution Form. If funds are from a rollover or transfer, complete a Rollover/Transfer Form or an IRA to HSA Transfer Request Form.</p>				
<p>HSA Trust Agreement: The terms of the HSA are set forth in the <i>Health Savings Account Trust Agreement for Employees and Individuals</i> and the <i>Addendum to the Health Savings Account Trust Agreement for Employees and Individuals</i> (collectively, the "Trust Agreement"). The Trust Agreement is available online at www.wellsfargo.com/HSA or by calling the Customer Service Center (number listed below). You will also be mailed a copy of the Trust Agreement in a "welcome packet" sent after your enrollment is processed.</p>				
<p>Establish HSA: I hereby request that <i>Wells Fargo Health Benefit Services (HBS)</i> establish an HSA in my name. I certify that I am eligible to contribute to an HSA under Internal Revenue Code §223. I acknowledge that my HSA will be established pursuant to the <i>Trust Agreement</i>. I understand that I may revoke this agreement within seven days of receiving the <i>Trust Agreement</i> in the welcome packet. I certify that <i>HBS</i> is authorized to act in accordance with any future documents bearing my signature. I further certify that the number shown on this form is my correct taxpayer identification number (TIN) (or I am waiting for a number to be issued to me). By signing this enrollment form, I authorize <i>HBS</i> to disclose account information to my spouse for recordkeeping purposes.</p>				
<p>FDIC Insured Account/Investment Fund Elections: I understand that uninvested funds in my HSA will be held in a Federal Deposit Insurance Corporation ("FDIC") insured interest-bearing deposit account ("Deposit Account"), pursuant to the <i>Trust Agreement</i>. Once I build a minimum balance in the Deposit Account, I will have the option to invest additional HSA contributions in mutual funds, including Wells Fargo Advantage Funds. Wells Fargo Funds Management, LLC serves as investment advisor and Wells Fargo Bank, N.A., serves as custodian for the Wells Fargo Advantage Funds. I understand that Wells Fargo Bank, N.A. will be paid, and certain of its affiliates may be paid, fees for services to the Wells Fargo Advantage Funds and that those fees are described in the prospectus for the particular fund.</p>				
<p>The USA PATRIOT ACT OF 2001 requires financial institutions to obtain, verify and record information to confirm the identity of each individual that opens an account. What this means for you: before you open an account, we will ask for your name, address, date of birth (if you are an individual), taxpayer identification number (TIN), and other information that will allow us to identify you. I certify that the purpose and funds for this account are for an HSA.</p>				
How were you referred to Wells Fargo Health Benefit Services?		<input type="checkbox"/> Employer <input type="checkbox"/> Other (please specify): _____		
<p>Beneficiary Designation: Please complete a <i>Designation/Change of Beneficiary Form</i> and send along with this enrollment form to the address below. You can obtain this form at www.wellsfargo.com/hsa or contact the Customer Service Center (number listed below). If you choose not to designate a beneficiary, any beneficiary distribution will be handled per the <i>Trust Agreement</i>.</p>				
Signature of Account Owner :			Date:	

Please mail this completed and signed form and a Designation/Change of Beneficiary Form to:
 Wells Fargo Health Benefit Services, P.O. Box 413042, Salt Lake City, UT 84141-3042

Questions? Please contact our Customer Service Center at (866) 890-8309
 Web site: www.wellsfargo.com/hsa

Funds may not be available for immediate withdrawal.

Health Savings Account (HSA) Designation/Change of Beneficiary



Mail completed, signed, and (if applicable) notarized form to:

Wells Fargo Health Benefit Services, P.O. Box 413042, Salt Lake City, UT 84141-3042

This Designation/Change of Beneficiary is subject to the provisions herein, which should be read carefully before completing this form.

HSA Owner's Name		Social Security Number	
Current Home Address	City	State	Zip Code
Current Employer Name	Current Health Insurance Carrier / Insurance Provider		

I hereby revoke any Designation of Beneficiary I may previously have made with respect to the above HSA and designate the following as my Beneficiary(ies):

Primary Beneficiary #1 First and Last Name*	Share (%)	Date of Birth (mm/dd/yyyy)	Social Security Number	Relationship
Current Home Address of Beneficiary #1		City	State	Zip Code
Primary Beneficiary #2 First and Last Name *	Share (%)	Date of Birth (mm/dd/yyyy)	Social Security Number	Relationship
Current Home Address of Beneficiary #2		City	State	Zip Code
Contingent Beneficiary #1 First and Last Name *	Share (%)	Date of Birth (mm/dd/yyyy)	Social Security Number	Relationship
Current Home Address of Contingent Beneficiary #1		City	State	Zip Code
Contingent Beneficiary #2 First and Last Name *	Share (%)	Date of Birth (mm/dd/yyyy)	Social Security Number	Relationship
Current Home Address of Contingent Beneficiary #2		City	State	Zip Code

Instructions to Account Holder: If you are changing your previous beneficiary election(s), your signature on this form must be notarized below.

State of _____ County of _____

On _____ before me, _____

Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity and that by his/her signature on the instrument the person, or entity upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal

Signature of Notary Public

(seal)

* Required field

I understand that the entire death benefit under the HSA will be paid to the primary beneficiaries who survive me in equal shares (unless different percentages are designated above). If no primary beneficiary survives me, the entire benefit will be paid to the contingent beneficiaries who survive me in equal shares (unless different percentages are designated above). If no primary or contingent beneficiary survives me, the entire death benefit will be paid according to the terms of the *Health Savings Account Trust Agreement for Employees and Individuals* ("Trust Agreement") for this HSA. If a primary or contingent beneficiary does not survive me, such beneficiary's interest shall lapse, and the percentage of any remaining beneficiaries shall be increased on a pro rata basis. If I have designated a Trust as beneficiary, the entire benefit will be paid to the Trust (unless different percentages are designated above). I may change this beneficiary designation at any time without the consent of any person or Trust named as a beneficiary (except as outlined below for marital/community property states). Neither this designation nor any future change of beneficiary will be effective unless filed with Wells Fargo Bank, N.A. before my death. This beneficiary designation and all rights to benefits are governed by the terms of the Trust Agreement for this HSA, as amended from time to time.

x	x
Signature of HSA Owner	Date (mm/dd/yyyy)

Trust Information If you wish to designate one or more trusts as beneficiary(ies) of your HSA, please complete the following section. All fields are required.

Name of Trust #1	Share (%)	Trustee Name	Taxpayer ID Number	Date of Trust	
Current Address of Trustee			City	State	Zip Code
Name of Trust #2	Share (%)	Trustee Name	Taxpayer ID Number	Date of Trust	
Current Address of Trustee			City	State	Zip Code

Instructions to Account Holder: If you are changing your previous beneficiary elections, your signature on this form must be notarized below.

State of _____ County of _____

On _____ before me, _____

Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity and that by his/her signature on the instrument the person, or entity upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal

Signature of Notary Public

(seal)

Signature of HSA Owner

Date (mm/dd/yyyy)

Spousal Consent**Instructions to HSA Owner who resides in or establishes an HSA in a community or marital property state and names a beneficiary other than his or her spouse.**

It is your responsibility to determine whether spousal consent is necessary. Failure to have your spouse sign below may invalidate your beneficiary designation for a portion of your HSA. Please consult your tax or legal advisor if you have questions about this section.

Spousal Consent

I am the spouse of the HSA Owner named above. I understand that my spouse is naming a beneficiary for the HSA other than myself. I approve and consent to the naming of said beneficiary, and I hereby transmute (transfer) and partition any community property interest I have or would otherwise have in this HSA into the separate property of my spouse for disposition as my spouse sees fit. I understand the consequences of giving up my interest, and acknowledge that I have been advised to seek tax or legal advice regarding these consequences.

Signature of Spouse

Date (mm/dd/yyyy)