American Health Value, LLC
Health Savings Account (HSA) Application

Date Account Opened
Account Number
Plan Number

Office use only

This is not your Medical Insurance Policy; contact your insurance carrier (or agent) to make changes to your insurance.

TYPE OF ACCOUNT: (Please check all that apply.)

Federally Qualified HSA ____ (Tax Deductible)
State Qualified HSA ___ (Tax benefits vary from state to state) **Non-Qualified HSA** ___ (Not tax deductible)
Account Funded By: ___ Employer ___ Employee ___Both

Notification of funding must be reported to the IRS

COPY OF VALID DRIVER'S LICENSE MUST BE INCLUDED WITH APPLICATION

ACCOUNT HOLDER INFORMATION **Please Print Clearly**

Name ______________________________ Social Security #________________ Date of Birth________________

Email Address **(Required)** ______________________________ Mother's Maiden Name____________________

Mailing Address ____

City______________________________ State________________ Zip______________

Residential Address (not a PO Box)____

City______________________________ State________________ Zip______________

Home Phone (_______)________________ Work Phone (_______)________________ Fax (_______)______________

Drivers License #____________________________ State of Issuance______________

POWER OF ATTORNEY (POA) (OPTIONAL)

Since regulations require that only one individual owns the HSA Account, the account holder may want their spouse and/or another third party through Power of Attorney to write checks or use their Debit Card. I (account holder) hereby designate the following individual as additional authorized signer on my Health Savings Account.

Name ______________________________ Social Security #________________ Date of Birth________________

EMPLOYER INFORMATION

Name of Employer ____

Mailing Address ____

City______________________________ State____________ Zip__________

Work Phone (_______)______________ Fax (_______)______________

Email Address ______________________________ Type of Business ______________________________

MUST BE COMPLETED BEFORE ACCOUNT CAN BE PROCESSED

Insurance Carrier____________________________ Effective Date of Policy____________ Insurance Deductible $_________

Benefit Options- Check All That Apply:

*****Free Kmart Prescription Discount Card______**

PR______VS______NS______CR______DT______AM______MD______IPS______NPS______

For additional information on the Optional Discount Benefits See the Process Packet under the Optional Benefits Page
Also, Logon to: www.americanhealthvalue.com or Call: 800-914-3248

Payment enclosed with application:

Opening Deposit (minimum $30.00)	$__________
Annual Fee ($36.00)	$__________
Set Up Fee ($15.00 – waived on rollovers):	$__________
Optional Benefits:	$__________
TOTAL ENCLOSED AMOUNT:	**$__________**

Broker Name ______________________________

Broker AHV Number ______________________________

-CONTINUED ON OTHER SIDE-

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AMERICAN HEALTH VALUE HEALTH SAVINGS ACCOUNT - PAGE TWO
BENEFICIARY(IES):

In the event of my death, I name as:

PRIMARY BENEFICIARY (Shares must equal 100%)

Name ______________________ Mailing Address ______________________
Relationship ______________________ City ____________ State ______ Zip ______
Social Security Number ______________________
Date of Birth ______________________ Share (Percent of holding) ______%

Name ______________________ Mailing Address ______________________
Relationship ______________________ City ____________ State ______ Zip ______
Social Security Number ______________________
Date of Birth ______________________ Share (Percent of holding) ______%

SECONDARY BENEFICIARY (Shares must equal 100%)

Name ______________________ Mailing Address ______________________
Relationship ______________________ City ____________ State ______ Zip ______
Social Security Number ______________________
Date of Birth ______________________ Share (Percent of holding) ______%

Name ______________________ Mailing Address ______________________
Relationship ______________________ City ____________ State ______ Zip ______
Social Security Number ______________________
Date of Birth ______________________ Share (Percent of holding) ______%

The above designations are subject to the Conditions of Beneficiary Designation listed below.

Conditions of Beneficiary Designation:

1. This designation is subject to all the terms and provisions of the agreement and shall be effective only if received by the trustee prior to the death of the person executing it.
2. This designation applies to the account holder's entire interest, if any, in trust account assets remaining undistributed at the account holder's death.
3. Each payment shall be made pursuant to this designation: (a) shall be paid in equal shares to the primary beneficiaries who are living at the time of the account holder's death or (b) if no primary beneficiary is living at the time, such payment shall be made in equal shares to the contingent beneficiaries who are then living at the time of the account holder's death.
4. This designation may be changed only by filing a written Change of Beneficiary Designation with the trustee.

Spousal Consent:

This section should be reviewed if either the trust of the residence of the HSA holder is located in a community or martial property state and the HSA holder is married. Due to important tax consequences of giving up one's community property interest, individuals signing this section should consult with a competent or legal tax advisor:

CURRENT MARTIAL STATUS

☐ I am not married – I understand that if I become married in the future, I must complete a new HSA Designation of Beneficiary form.
☐ I am married – I understand that if I chose to designate a primary beneficiary other than my spouse, my spouse must sign below.

I am the spouse of the above named HSA 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. I hereby give the HSA holder any interest I have in the funds or property deposited in this HSA and consent to the beneficiary designation indicated above. I assume full responsibility for any adverse consequences that my result. No tax or legal advise was given to me by the Custodian.

Spouse – Signature Required	Date	Notary – Signature Required	Date
	/ /		/ /

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ACCEPTANCE OF TERMS:

By my signature below I understand that SETUP FEES and ANNUAL FEES are NON-REFUNDABLE and I apply, and the institution by its signature accepts my application to establish a Health Savings Account pursuant to the terms of the Health Savings Account Agreement and Disclosure Statement (available at www.ahvthebancorp.com), which is incorporated into this application by reference. I authorize the bank to provide American Health Value all data necessary to maintain the account.

The account holder is responsible for the establishment and maintenance of this account pursuant to Federal guidelines. American Health Value is here to assist the account holder in accomplishing this.

HEALTH SAVINGS ACCOUNT TRUST AGREEMENT:

I acknowledge that I have received a copy of the Health Savings Account Trust disclosure statement. The trustee or administrator is authorized to act without further inquiry in accordance with writings bearing my signature. I understand that I may revoke the agreement by written notice to the trustee or administrator within seven (7) days after the date of the agreement as specified below.

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. We may also ask to see your driver's license or other identifying documents.

This deposit account is subject to all applicable rules and regulations adopted by The Bancorp Bank. My signature acknowledges my acceptance of the Truth in Savings Disclosure governing these accounts. The Bancorp Bank may order a consumer report from a credit reporting agency in order to evaluate whether to issue a Debit Card for those consumers who have applied. The Truth in Savings Disclosure is available at www.ahvthebancorp.com.

Primary Applicant – Signature Required	Date	Power of Attorney – Signature Required	Date
	/ /		/ /

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 to me), and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding under Internal Revenue Service (IRS) regulations, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the Internal Revenue Service has notified me that I am no longer subject to backup withholding, and 3. I am a U.S. person (including a U.S. resident alien).

CERTIFICATION INSTRUCTIONS – You must cross out item 2 above if you have been notified by the Internal Revenue Service that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return.

THE INTERNAL REVENUE SERVICE DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE CERTIFICATION REQUIRED TO AVOID BACKUP WITHOLDING.

Primary Applicant – Signature Required	Date	Power of Attorney – Signature Required	Date
	/ /		/ /

MAIL COMPLETED APPLICATION TO: INSURERS OF IDAHO, 14186 W. Chadford, Boise, ID 83713

THE BANCORP BANK

Trustee under the agreement, hereby acknowledges receipt of the above application and successor designation.

____
By Authorized Officer

---OFFICE USE ONLY---

BenCalc: ______	Refund $______	Contributions to Existing Accounts $______
Check #: ______	☐ Member	
	☐ Employer	
Amt. Rec'vd. $______		Rollover $______
Current Year $______	Apply to Inv. $______	
Previous Year $______	☐ Member	Fees Due
Set-Up Fee $______	☐ Employer	Annual $______
Annual Fee $______		Set Up $______
Bank Fees $______		Member / Employer / EFT

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ANNUAL FEE PAYMENT METHOD

I understand that my annual fee for the first year must be submitted with this application. This authorization pertains to future years.

I(We) authorize American Health Value, LLC to transfer funds between the accounts held in the institutions listed below, for the purpose of Annual Account Administration Fee Payment. I (We) authorize the institution so named to accept the debit or credit entries initiated by American Health Value, LLC and to pay the agreed Annual Account Administration Fee. This agreement may be terminated at anytime by written notification. Such notification shall be effective only with respect to entries by American Health Value, LLC, after American Health Value, LLC or customer receives notification and has had a reasonable time to act. By my (our) signature(s) bellow, I (we) guarantee that I (we) have legal right to conduct any and all business on the accounts listed below.

PLEASE COMPLETE ONE OF THE FOLLOWING:

METHOD	NAME ON ACCOUNT	ACCOUNT NUMBER	EXPIRATION
☐ VISA/MASTERCARD			
☐ HSA ACCOUNT		Office Use	N/A
☐ ELECTRONIC TRANSFER			
☐ PLEASE INVOICE			
Please enclose a “voided” check from the bank that is to be debited			

X______________________________
Signature of Account Holder Date

X______________________________
Signature of Account Holder Date

X______________________________
Print Name Date

X______________________________
Print Name Date

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Schedule of Fees

American Health Value offers quality Health Savings Account administration for both qualified and non-qualified accounts. We offer interest on the deposits into your checking account and an investment option in mutual funds. Your AHV Debit MasterCard® provides easy access to the funds in your account.

American Health Value Fees and Requirements

*One-time Setup Fee	$15.00 - Set up fee is waived on rollovers if annual fee is paid in full when account is opened.
*Annual Fee:	$36.00 - See optional benefits on back of this form.
Minimum Deposit Requirement:	$30.00
Minimum Balance Requirement:	$30.00

***Fees are not refundable. Be sure your insurance is in effect before submitting your HSA application.**

Bank Fees

$2.50 monthly service charge. (Monthly service charge is waived if account balance during the month does not drop below $2,500.00)

Other charges may apply based on use.

Tips for Using Your Checkbook and Debit MasterCard® Card

Use your AHV Debit MasterCard to pay for your health care expenses at time of service, anywhere in the world where MasterCard is accepted.

Use your checkbook to pay for your health care expenses if your provider does not accept MasterCard or if you are paying by mail and do not wish to send your MasterCard information through the mail.

Remember to keep receipts for your tax records.

American Health Value – Optional Benefits

OPTIONAL BENEFIT PRICING		
BENEFIT DESCRIPTION	BENEFIT CODE	PRICE PER YEAR
Enhanced Pharmacy Network	**PR**	$12.00
Vision Network	**VS**	$12.00
Nurse-On-Call	**NS**	$12.00
Chiropractic Network	**CR**	$12.00
Dental Network	**DT**	$21.00
Alternative Medicine Benefit	**AM**	$21.00
National Point of Service Network	**NPS**	$36.00
Preferred Provider Network	**MD**	$27.00
International Point of Service Network	**IPS**	$12.00

Enhanced Pharmacy Network
Med-Care's neighborhood pharmacy network provides savings at over 45,000 pharmacies nationwide. Members also have access to a mail order and Internet pharmacy center.

Vision Network
With the Vision Network, members receive savings on eye exams, frames, prescription lenses, contacts, non-prescription sunglasses and surgical procedures (including LASIK surgery). There are over 10,000 vision care locations nationwide.

Nurse-On-Call
Nurse-on-Call offers Members toll-free telephone access to experienced, registered nurses 24 hours a day, 365 days a year. The nurses are an immediate, reliable and caring source of health and medical information, education, and support.

Chiropractic Network
The Med-Care Plus Chiropractic program offers savings from over 12,000 providers nationwide, including free initial consultations and up to 50% savings on other services.

Dental Network
Members receive savings of 20%-60% on their dental care needs, including cosmetic dentistry and orthodontics. This network has over 20,000 providers nationwide.

Alternative Medicine Benefit
Members save 20%-30% on services from over 10,000 providers nationwide. Services include acupuncture, acupressure, homeopathy, herbology, meditation, massage therapy, aromatherapy, nutritionists, holistic medicine, and yoga.

National Point of Service Network
Members receive savings of up to 25% and more at over 230,000 physician locations across the country. Contracted providers apply the savings and you pay the reduced amount, in full, directly to the provider at the time of service.

Preferred Provider Network
Physician, Hospital, and Laboratory Program provides special-pricing options with over 350,000 physicians, 55,000 ancillary facilities (labs, radiology clinics, etc.), and over 70% of the hospitals nationwide.

International Point of Service Network
This network includes Central and South America and the Caribbean. It is composed of over 550 hospitals and the nearly 20,000 physicians affiliated with these hospitals in 26 countries. Members receive savings of up to 25% and more when they pay in full at time of service

For more detailed information on these benefits please see the AHV Med-Care Plus program brochure or visit our website at www.americanhealthvalue.com