Atlantic Stewardship Bank

HSA NEW ACCOUNT FORM

HSA ACCOUNT HOLDER

Name (First) _____ (MI)_____ (Last)_____

Street Address _____City _____State____ Zip_____

Mailing Address_____City_____State_____ Zip_____

Drivers License Number _____State _____Expiration Date_____

Day Phone _____ Evening Phone_____

E-Mail Address (Stays in-house, never given out):_____

Date of Birth ____/_____/_____ Social Security Number _____-_____-_____

I state that I have a Qualified High Deductible Health Plan (QHDHP) with _____Insurance

My policy deductible is $_____ Maximum out of Pocket $_____

Effective Date ____/____/____ I have a ☐ single ☐ family policy.

HSA contributions: Year_____ Opening contribution $_____ Catch-up contribution $_____

*Yearly maximum contribution for individuals is $3,500 for 2019 and $3,550 for 2020.
*Yearly maximum contribution for a family is $7,000 for 2019 and $7,100 for 2020.

**You may add the "catch up contribution" to these numbers if you qualify. If you're 55 or older any time in 2019, you may add an additional $1,000 for 2019 and beyond.

Please check below if applicable. Transfers from an existing hsa account (trustee to trustee transfer) require a separate form (see HSA forms/Rollover) and a copy of your latest statement from that institution. Rollovers mean you have actually taken possession of funds from a previous account.

I wish to do the following:

☐ Trustee to Trustee transfer—please include statement from current account—transfers may require 60-day processing

☐ Rollover: I understand that I am only allowed one rollover in a 12-month period.

PLEASE COMPLETE BELOW IF YOUR EMPLOYER IS CONTRIBUTING ON YOUR BEHALF:

Employer Contribution $_____ Employer Name_____

Employer Address_____

☐ Rollover: I understand that I am only allowed one rollover in a 12-month period. ☐ Trustee to Trustee transfer ☐

ADDITIONAL HSA ACCOUNT SIGNER: I hereby designate this individual as an additional signer on my HSA.

First_____ MI_____ Last_____

SSN_____-_____-_____ Date of Birth _____/_____/_____

Drivers License Number _____State_____ Expiration Date____/_____

Additional debit card YES ☐ NO ☐

Signature of additional signer _____Date_____

BENEFICIARY(IES) SEE TERMS OF WILL☐ (If you have a will, check here)

At the time of my death, the primary beneficiaries named below will receive my HSA assets. If all of my primary beneficiaries die before me, the contingent beneficiaries named below will receive my HSA assets. In the event a beneficiary dies before me, such beneficiary's share will be reallocated on a pro-rata basis to the other beneficiaries that share the deceased beneficiary's classification as a primary or contingent beneficiary. If all of the beneficiaries die before me, my HSA assets will be paid to my estate. If no percentages are assigned to beneficiaries, the beneficiaries will share equally. If the percentage total for each beneficiary classification does not equal 100 percent, any remaining percentage will be divided equally among the beneficiaries within such class. This designation revokes and supersedes all earlier beneficiary designations which may apply to this HSA.

Primary Beneficiary(ies)
Name Address SSN Relationship DOB
Percentage

_____/____/_____%

_____/____/_____%

_____/____/_____%

_____/____/_____%

_____/____/_____%

Information for spouse: I am the spouse of the HSA owner. Because of the significant consequences associated with giving up my interest in the HSA, the custodian has not provided me with legal or tax advice, but has advised me to seek tax or legal advice. I acknowledge that I have received a fair and reasonable disclosure of the HSA owner's assets or property, including any financial obligations for a community property state. In the event I have a legal interest in the HSA assets, I hereby give to the HSA owner such interest in the assets held in this HSA and consent to the beneficiary designation set forth in this form.

If married signature of spouse _____ Date____/____/_____

☐ I am single

If this HSA is being established with a regular contribution, I certify that I am covered by a qualified high deductible health plan (HDHP), and that I am not covered by a health plan other than an HDHP that provides any of the same benefits as an HDHP. If this HSA is being established with a rollover or transfer contribution, I certify that the rollover or transfer assets are from another HSA or Archer Medical Savings Account (MSA). I certify that the information provided by me on this Application is accurate, and that I have received a copy of the Application, Health Savings Custodial Account, and Disclosure Statement. I agree to be bound by the terms and conditions found in the Application, Health Savings Custodial Account, Disclosure Statement, and amendments thereto. I assume sole responsibility for all consequences relating to my actions concerning this HSA. I understand that I may revoke this HSA on or before seven (7) days after the date of establishment. I have not received any tax or legal advice from the custodian, and I will seek the advice of my own tax or legal professional to ensure my compliance with related laws. I release and agree to hold the HSA custodian harmless against any and all claims or losses arising from my actions.
Atlantic Stewardship Bank 630 Godwin Avenue Midland Park, NJ 07432

Signature of HSA account holder_____ Date_____/____/_____

Health Savings Account
Custodial Agreement

The depositor whose name appears on the attached Application is establishing a Health Savings Account (HSA) under Section 223(a) of the Internal Revenue Code
("Code") for the purpose of paying qualified medical expenses, as defined under Section 223(d)(2) of the Code, of the Depositor. The Depositor has assigned the custodial account the sum indicated on the Application.

ARTICLE I

The Custodian may accept additional cash contributions on behalf of the Depositor for the tax year. The total cash contributions are limited to the maximum allowed under Section 223(b) of the Code for the tax year unless the contribution is a rollover contribution described in Section 223(f)(5) of the Code.

ARTICLE II

The Depositor's interest in the balance in the custodial account is non-forfeitable.

ARTICLE III

No part of the Custodial Funds may be invested in life insurance contracts, nor may the assets of the Custodial account be commingled with other property, except in a common trust fund or common investment fund.

ARTICLE IV

If the Depositor dies before his or her entire interest is distributed to him or her, the entire remaining interest will be disposed of as follows:

1. If the beneficiary is the Depositor's spouse, the HSA shall become the spouse's HSA as of the date of death.

2. If the beneficiary is not the Depositor's spouse, the HSA shall cease to be an HSA as of the date of death, and the fair market value of the account shall be taxable to the beneficiary (or the estate) in the taxable year which includes such date.

ARTICLE V

1. The Depositor agrees to provide the Custodian with information necessary for the Custodian to prepare any reports required by the Code and related regulations.

2. The Custodian agrees to submit any reports to the Internal Revenue Service and the Depositor prescribed by the Internal Revenue Service.

ARTICLE VI

This Agreement will be amended from time to time to comply with the provisions of the Code and related regulations. Other amendments may be made with the consent of the HSA Holder whose signature appears on the Application and the Custodian.

ARTICLE VII

1. Definitions: In this part of the Agreement (Article VII), the words "you" and "your" refer to the Depositor. The Depositor is the person who establishes the custodial account. The words "we," "our," and "us" refer to the Custodian. The Custodian must be a bank or credit union, as defined in Section 408(n), insurance company, or other person who has the approval of the Secretary of the Treasury to act as Custodian. The word "Code" means the Internal Revenue Code.

2. Notices and Changes of Address: Any required notice regarding this HSA will be considered effective when we mail it to the last address of the intended recipient which we have in our records. Any notice to be given to us will be considered effective when we actually receive it. You must notify us of any changes of address.

3. Representations and Responsibilities: You represent and warrant to us that any information you have given or will give us with respect to this Agreement is complete and accurate. Further, you agree that any directions you give us, or any action you take will be proper under this Agreement, and that we are entitled to rely upon any such information or directions. We shall not be responsible for losses of any kind that may result from your directions to us or your actions or failures to act, and you agree to reimburse us for any losses we may incur as a result of such directions, actions or failures to act. We shall not be responsible for any penalties, taxes, judgments or expenses you incur in connection with your HSA. We have no duty to determine whether your contributions or distributions comply with the Code, regulations, rulings, or this Agreement.

4. Service Fees: We have the right to charge an annual service fee or other designated fees (e.g., a transfer, withdrawal or termination fee) for maintaining your HSA. In addition, we have the right to be reimbursed for all reasonable expenses we incur in connection with the administration of your HSA. We may charge you separately for any fees or expenses, or we may deduct the amount of the fees or expenses from the assets in your HSA, at our discretion. We reserve the right to charge any additional fee upon thirty (30) days notice to you prior to the date that the fee will become effective.

5. Investment of Amounts in the HSA: Your HSA assets shall be invested in a Atlantic Stewardship Bank Health Savings Account, and shall be subject to any and all restrictions or limitations, direct or indirect, which are imposed by or flow from the bylaws of our organization, and all Federal and State laws and regulations which apply to us.

6. Beneficiaries: You may designate one or more person(s) or entity(ies) as beneficiary(ies) of your HSA. This designation can only be made on a form prescribed by us, and it will only be effective when it is filed with us during your lifetime. Unless specified otherwise in writing by you, each beneficiary designation you file with us will cancel all previous ones. The consent of a beneficiary shall not be required for you to revoke a beneficiary designation. If you do not designate a beneficiary, your estate will be the beneficiary.

7. Termination: Either party may terminate this Agreement at any time by giving written notice to the other. We can resign as Custodian at any time effective thirty (30) days after we mail written notice of our resignation to you. Upon receipt of that notice, you must make arrangements to transfer your HSA to another financial organization. If you do not complete a transfer of your HSA within thirty days from the date we mail the notice to you, we have the right to transfer your HSA assets to a successor HSA custodian or trustee that we choose in our sole discretion, or we may pay your HSA to you in a single sum. We shall not be liable for any actions or failures to act on the part of any successor custodian or trustee, nor for any tax consequences you may incur that result from the transfer or distribution of your assets pursuant to this Section.

If this Agreement is terminated, we may hold back from your HSA a reasonable amount of money that we believe is necessary to cover any one or more of the following:

- Any fees, expenses or taxes chargeable against your HSA;
- Any penalties associated with the early withdrawal of your HSA.

If our organization is merged with another organization (or comes under the control of any Federal or State agency), or if our entire organization (or any portion which includes your HSA) is bought by another organization, that organization (or agency) shall automatically become the trustee or custodian of your HSA, but only if it is the type of organization authorized to serve as an HSA trustee or custodian. If we fail to comply with certain Treasury regulations, or we are not keeping the records, making the returns, or sending the statements that are required by forms or regulations, the IRS may, after notifying you, require you to substitute another custodian or trustee.

8. Amendments: We have the right to amend this Agreement at any time. Any amendment we make to comply with the Code and related regulations does not require your consent. You will be deemed to have consented to any other amendments unless, within thirty (30) days from the date we mailed the amendment, you notify us in writing that you do not consent.

9. Withdrawals: All requests for withdrawal shall be in writing on a form provided by or acceptable to us, or by Check Card if use of this option is authorized in the Application. The method of distribution must be specified in writing. The tax identification number of the recipient must be provided to us before we are obligated to make a distribution. Any withdrawals shall be subject to all applicable tax and other laws and regulations, including possible early withdrawal penalties and withholding requirements.

10. Transfer from Other Plans: We can receive amounts transferred to this HSA from the custodian or trustee of another HSA or Medical Savings Account. However, we also reserve the right to refuse any transfer.

11. Liquidation of assets: We have the right to liquidate assets in your HSA if necessary to make distributions, or to pay fees, expenses, or taxes properly chargeable against your HSA. If you fail to direct us which assets to liquidate, we will decide in our complete and sole discretion, and you agree not to hold us liable for any adverse consequences that result from our decision.

12. Restrictions on the Fund: Neither you nor any beneficiary may sell, transfer or pledge any interest in your HSA in any manner whatsoever, except as provided by law or this Agreement. The assets in your HSA shall not be responsible for the debts, contracts or torts of any person entitled to distributions under this Agreement.

13. Applicable Law: This Agreement is subject to all applicable Federal and State laws and regulations. If it is necessary to apply any State law to interpret and administer this Agreement, the law of our domicile shall govern. If any part of this Agreement is held to be illegal or invalid, the remaining parts shall not be affected. Neither your nor our failure to enforce at any time or for any period of time any of the provisions of the Agreement shall be construed as a waiver of such provisions, or your right or our right thereafter to enforce each and every such provision.

We shall not be liable to you for any losses, damages, costs, penalties, or expenses you incur as a result of your employer's failure to make the contributions to your HSA required under your employer's health plan. We are not responsible for monitoring your employer's contributions to your HSA, or notifying you of your employer's contributions. You are responsible for contacting your employer regarding its contributions and monitoring those contributions. We will provide monthly statements to you. We shall not be liable to you for any statements, representations, actions or inactions of any insurance agent or agency that sold you an insurance plan in connection with your HSA. An insurance agent or agency is not our partner, agent, affiliate, representative or co-venture.