

**MAKE CHECK PAYABLE TO CAMBRIDGE STATE BANK**

A. One-time Set up fee	\$25.00
C. Opening Deposit	\$50.00
D. Check Order \$12.00 or \$16.00	\$ _____
E. Initial Contribution:	\$ _____
F. Additional Debit Card (if applicable)	\$ _____
G. Total Amount Enclosed:	\$ _____

127 South Main St, Cambridge—www.cambridgestatebank.com— 763.689.2500—Member FDIC

**HEALTH SAVINGS ACCOUNT (HSA) APPLICATION**

To avoid processing delays, please complete all fields on the application—shaded fields are optional, starred fields (\*) are required.

**Mail** your completed application  
(and opening deposit, setup fee, check order, if applicable) to:  
Cambridge State Bank, P.O. Box 472, Cambridge, MN 55008

**Or fax** this form to: 763.689.5153  
And mail opening deposit, original application, if applicable separately to:  
Cambridge State Bank, P.O. Box 472, Cambridge, MN 55008

**PART 1: PERSONAL INFORMATION—ACCOUNT HOLDER**

\*SOCIAL SECURITY #

\*DATE OF BIRTH

\*FIRST NAME

\*MIDDLE INITIAL

\*LAST NAME

\*STREET ADDRESS (NOT P.O. BOX)

MAILING ADDRESS (if different than street address)

\*CITY

CITY

\*STATE

\*ZIP

STATE

ZIP

\*HOME PHONE # WITH AREA CODE

\*OTHER PHONE # WITH AREA CODE

\*MOTHER'S MAIDEN NAME

WORK PHONE # WITH AREA CODE &amp; EXT

EMAIL ADDRESS

**PER THE US PATRIOT ACT:**

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. On the account application, 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 a copy of your driver's license or other identifying documents.

**\*FORM OF IDENTIFICATION**(CHECK ONE):  Driver's License  State ID  Passport

\*IDENTIFICATION #

\*STATE OF ISSUANCE

**PART 2: HIGH-DEDUCTIBLE HEALTH PLAN (HDHP)**

\*Who is covered? (check one)

 Individual  Family (Individual + Dependent(s))\*Are you enrolling in an HSA through your employer? (check one):  No  Yes If yes, provide employer's name:**PART 3: BACKUP WITHHOLDING CERTIFICATIONS**

Check Appropriate Box(es)

 \*Taxpayer I.D. Number—The taxpayer identification number shown above (TIN) is my correct taxpayer identification number. \*Backup Withholding—I am not subject to backup withholding either because I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to back up withholding. \*Exempt Recipients—I am an exempt recipient under the Internal Revenue Service Regulations.

\*INITIAL HERE \_\_\_\_\_: I certify that under penalties of perjury the statements checked in this section and that I am a U.S. person (including a U.S. resident alien).

**PLEASE COMPLETE NEXT PAGE**



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## HEALTH SAVINGS ACCOUNT (HSA) APPLICATION

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### PART 4: AUTHORIZED SIGNER—(OPTIONAL)

Regulations require that only one individual own a Health Savings Account, therefore the account holder may want to designate his/her spouse and/or another third-party to write checks or use a debit card. I (account holder) hereby designate the following individual as additional authorized signer on my Health Savings Account. Authorized Signer's debit card will be mailed to Account holder's address on file.

AUTHORIZED USER'S FIRST NAME	AUTHORIZED USER'S MIDDLE INITIAL	AUTHORIZED USER'S LAST NAME
AUTHORIZED USER'S DATE OF BIRTH	AUTHORIZED USER'S SOCIAL SECURITY #	
AUTHORIZED USER'S FORM OF IDENTIFICATION (CHECK ONE): <input type="checkbox"/> Driver's License <input type="checkbox"/> State ID <input type="checkbox"/> Passport	IDENTIFICATION #: STATE OF ISSUANCE:	<b>NOTE: Authorized signer authorizes the financial institution to verify credit and employment history and/or have a credit reporting agency prepare a credit report on the authorized signer.</b>
AUTHORIZED USER'S STREET ADDRESS		
AUTHORIZED USER'S CITY	AUTHORIZED USER'S STATE	AUTHORIZED USER'S ZIP
AUTHORIZED USER'S SIGNATURE	PLEASE ISSUE AN ADDITIONAL DEBIT CARD FOR AUTHORIZED SIGNER <input type="checkbox"/> CHECK HERE TO ORDER A CARD	

### PART 5: BENEFICIARY INFORMATION (OPTIONAL)

If you do not designate otherwise, your estate will be the beneficiary of your HSA upon your death. To designate an alternative beneficiary, please complete a Designation of Beneficiary form, included in this packet or on www.cambridgestatebank.com or request one from customer service, at 763.689.2500

### PART 6: REQUIRED SIGNATURES (Please read before signing)

- I understand that Cambridge State Bank is the custodian of the account and I meet the eligibility requirements for deposits made to my Health Savings Account (HSA) and state that I qualify to make deposits to this account. I have reviewed this application, the Health Savings Account (HSA) Schedule of Fees and Charges, HSA Custodial and Deposit Agreement and Privacy Notice. By signing below, I understand and agree to be bound by the terms and conditions that apply to this HSA as outlined in these documents. Within seven (7) calendar days from the date I open this HSA I may revoke the authorization by mailing a written notice to Cambridge State Bank (set up fee non-refundable).
- I assume complete responsibility for:
  - Determining my eligibility for an HSA each year I make a contribution.
  - Ensuring all contributions made to my account are within the limits set forth by the tax laws.
  - Any tax consequences of contributions (including rollover contributions) and distributions.
- I authorize Cambridge State Bank to provide information about my HSA, including my account number, to my employer (if applicable), and those acting on behalf to establish and maintain my HSA.
- I acknowledge that my employer, and others acting on behalf of my employer (if applicable), may provide information on my behalf to establish and maintain my HSA.
- I certify that the information provided in this application is true and complete.

X \_\_\_\_\_

\*Account Holder—Signature Required \*Date

**IMPORTANT: We cannot process this application without your signature. Please keep a copy of this application for your records.**

### PART 7: ACCOUNT OPTIONS

- I would like 1 free debit card issued in my name for my account.  Yes  No
- I would like 1 additional debit card issued in the Authorized User's name for my account.  Yes  No (Each additional card \$5.00 one-time fee)
- I would like to order checks for my HSA. SELECT OPTION A OR B—  A) 25 duplicate checks and 10 deposit tickets—\$12.00  B) 50 duplicate checks and 20 deposit tickets- \$16.00
- I would like to be enrolled in online banking.  Yes  No
- Opening Deposit Required: \$50.00 and One Time Setup Fee \$25.00



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**ONLINE BANKING**  
Complete this form and return to Cambridge State Bank

**Mail** your completed application  
to: Cambridge State Bank, ATTN: HSA SPECIALIST,  
P.O. Box 472, Cambridge, MN 55008

**Or fax** this form to: 763.689.5153 ATTN: CINDY SZAFRANSKI  
And mail to: Cambridge State Bank, ATTN: HSA SPECIALIST,  
P.O. Box 472, Cambridge, MN 55008

**PART 8: ONLINE BANKING**

SOCIAL SECURITY #		PREFERRED USER ID FOR ONLINE ACCESS—Must be at least 6 digits, alpha and/or numeric, it will be case sensitive.	
FIRST NAME	MIDDLE INITIAL	LAST NAME	
STREET ADDRESS (NOT P.O. BOX)		EMAIL ADDRESS	
CITY	DATE OF BIRTH	OTHER PHONE # WITH AREA CODE	
STATE	ZIP	HOME PHONE # WITH AREA CODE	

Once your application is approved you will receive a Welcome Letter in the mail within 3 business days which will detail your UserID and Password to sign into online banking.

**PART 9: SIGNATURE/AUTHORIZATION**

I/We agree that my use of the Online Banking Service in connection with my account(s) at Cambridge State Bank (CSB) constitutes my acceptance and agreement to be bound by all of the terms and conditions of this Agreement and of the Deposit Account Terms and Conditions. Further I agree to pay all telephone charges or fees incurred by accessing Online Banking Services. CSB reserves the right to terminate your online banking privileges at any time.

Balances in the account(s) is the “available balance” as of the current business day (Saturday’s, Sunday’s or Holiday’s are NOT included) and can be obtained online. To process a transfer, sufficient “available” funds must be in the account(s). Transfers conducted during our business hours (8:00 a.m.—5:00 p.m.) will post to the account same business day. Transfers after our 5:00 p.m. Online Banking cut-off time will not post to the account(s) until the next business day. Federal regulations restrict the number of pre-authorized transfers out a savings account or money market account to six (6) per month. Please see your account disclosure for a more detailed description.

Every effort will be made to minimize the amount of time the system is unavailable. Due to routine maintenance the system may be temporarily unavailable. We will try and inform you by posting a message on our site when we know of scheduled down times. When Online Banking is unavailable we ask that you use our Tele-Bank service, ATMs or stop into the Bank during business hours. CONSUMER ACCOUNTS will receive a “Welcome Letter” within three (3) business days after the application is accepted. For general questions, contact Cindy Szafanski by phone at 763.691.8016. By signing this agreement, I acknowledge that I have read and accept the disclosures as provided.

**IMPORTANT:**

The account holder agrees as follows: The owner of the account will be liable if he/she shares the online banking UserID and/or Password and all transactions that occur on the account. The owner of the account authorizes all transactions made by any other person. The availability of all services described in this Application are subject to approval of Cambridge State Bank.

**HSA ACCOUNT HOLDER: PLEASE PRINT NAME** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



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## Health Savings Account Custodial Agreement

This agreement is made between Cambridge State Bank, (referred to herein as the "Custodian") and the individual person (referred to herein as "Customer") who completes the Application Form and other documents in which the Customer applies to open a Health Savings Account ("HSA") with the Custodian. Customer is establishing this Health Savings Account under Section 223 of the Internal Revenue Code (the "Code") exclusively for the purpose of paying or reimbursing qualified medical expenses of the Customer, his or her spouse, and dependents. Customer represents that, unless this account is used solely to make rollover contributions, he or she is eligible to contribute to this HSA; specifically, that he or she: (1) is covered under a high deductible health plan (HDHP); (2) is not also covered by any other health plan that is not an HDHP (with certain exceptions for plans providing preventive care and limited types of permitted insurance and permitted coverage); (3) is not enrolled in Medicare; and (4) cannot be claimed as a dependent on another person's tax return. Customer has made (or may make) an initial cash contribution to the custodial account as indicated in the Application Form or other relevant documents. The initial deposit, any additional contributions, and any earnings thereon shall be subject to the terms of this agreement. Customer and Custodian make the following agreement.

*The account owner and the custodian make the following agreement:*

### **Article I**

The custodian will accept additional cash contributions for the tax year made by the account owner or on behalf of the account owner (by an employer, family member or any other person). Customer represents that no contributions will be made that exceed the maximum amount for family coverage plus the catch-up contribution. Contributions for any tax year may be made at any time before the deadline for filing the account owner's federal income tax return for that year (without extensions). Rollover contributions from an HSA or an Archer Medical Savings Account (Archer MSA) (unless prohibited under this agreement) need not be in cash and are not subject to the maximum annual contribution limit set forth in Article II.

### **Article II**

For calendar year 2005, the maximum annual contribution limit for an account owner with single coverage is the lesser of the amount of the deductible under the HDHP but not more than \$2,650. For calendar year 2005, the maximum annual contribution limit for an account owner with family coverage is the lesser of the amount of the deductible under the HDHP but not more than \$5,250. These limits are subject to cost-of-living adjustments after 2005. Eligibility and contribution limits are determined on a month-to-month basis. Contributions to Archer MSAs or other HSAs count toward the maximum annual contribution limit to this HSA. For calendar year 2005, an additional \$600 catch-up contribution may be made for a Customer who is at least age 55 or older and not enrolled in Medicare. The catch-up contribution increases to \$700 in 2006, \$800 in 2007, \$900 in 2008, and \$1,000 in 2009 and later years. As with the annual contribution limit, the catch-up contribution is computed on a month-to-month basis. Contributions in excess of the maximum annual contribution limit are subject to an excise tax. However, the catch-up contributions are not subject to an excise tax. The tax will apply each year in which an excess remains in your HSA.

### **Article III**

It is the responsibility of Customer to determine whether contributions to this HSA have exceeded the maximum annual contribution limit described in Article II. If contributions to this HSA exceed the maximum annual contribution limit, the Customer shall notify the Custodian that there exist excess contributions to the HSA. It is the responsibility of Customer to request the withdrawal of the excess contribution and any net income attributable to such excess contribution.

### **Article IV**

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

### **Article V**

No part of the custodial funds in this account may be invested in life insurance contracts or in collectibles as defined in section 408(m). The assets of this account may not be commingled with other property except in a common trust fund or common investment fund. Neither Customer nor Custodian will engage in any prohibited transaction with respect to this account (such as borrowing or pledging the account or engaging in any other prohibited transaction as defined in section 4975).

### **Article VI**

Distributions of funds from this HSA may be made upon the direction of the Customer, subject to the limitations described in any product-related materials that may be provided to Customer as part of this Application Package. Distributions from this HSA that are used exclusively to pay or reimburse qualified medical expenses of the Customer, his or her spouse, or dependents are tax-free. However, distributions that are not used for qualified medical expenses are included in the Customer's gross income and are subject to an additional 10 percent tax on that amount. The additional 10 percent tax does not apply if the distribution is made after the Customer's death, disability, or reaching age 65. The Custodian is not required to determine whether the distribution is for the payment or reimbursement of qualified medical expenses. Only the Customer is responsible for substantiating that the distribution is for qualified medical expenses and must maintain records sufficient to show, if required, that the distribution is tax-free.

### **Article VII**

If the Customer dies before the entire interest in the account is distributed, the entire account will be disposed of as follows:

1. If the beneficiary is the account owner's spouse, the HSA will become the spouse's HSA as of the date of the death.
2. If the beneficiary is not the account owner's spouse, the HSA will cease to be an HSA as of the date of the death. If the beneficiary is the account owner's estate, the fair market value of the account as of the date of the death is taxable on the account owner's final return. For other beneficiaries, the fair market value of the account is taxable to that person in the tax year that includes such date.

Custodian shall have no duty, obligation or responsibility to make any inquiry or conduct any investigation concerning the identification, address, or legal status of any individual or individuals alleging the status of beneficiary nor to make inquiry or investigation concerning the possible existence of any beneficiary, claim, or election not reported to Custodian prior to the distribution of the account. Upon full and complete distribution of the Custodial account pursuant to the provisions of this Article, Custodian shall be fully and forever discharged from all liability respecting such account.

### **Article VIII**

The Customer agrees to provide the Custodian with information necessary for the Custodian to prepare any report or return required by the IRS. The Custodian agrees to prepare and submit any report or return as prescribed by the IRS. Except for any reporting requirements placed on Custodian by the IRS, Customer shall have complete responsibility for reporting to the IRS all contributions to and distributions from the custodial account, and for the tax consequences of all such contributions and distributions, including but not limited to rollovers, transfers, excess contributions and prohibited transactions. Customer acknowledges that Custodian has not, and will not, provide any tax advice in connection with the Custodial Account and that Customer should consult with Customer's tax advisor for any such advice. Customer shall be responsible for the payment of any taxes or penalties of any kind that may be assessed against the custodial account.

### **Article IX**

Notwithstanding any other article that may be added or incorporated in this agreement, the provisions of Articles I through VIII and this sentence are controlling. Any additional article in this agreement that is inconsistent with section 223 or IRS published guidance will be void.



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## Health Savings Account Custodial Agreement

### **Article X**

This agreement will be amended from time to time to comply with the provisions of the Code or IRS published guidance. Other amendments may be made with the consent of the persons whose signatures appear below. We may also make other amendments from time to time by sending a notice of the amendment to you. You will be deemed to accept the amendment unless you terminate this agreement within 30 days of receiving the notice.

### **Article XI**

All questions arising with respect to the provisions of this agreement shall be determined by application of the laws of the State of Minnesota except to the extent Federal law supersedes Minnesota law.

**Notices of 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.

We have the right to charge a monthly or annual service fee or other designated fees (example, 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 30 days notice to you that the fee will be effective.

You may designate one or more persons or entities as beneficiary of your HSA. This designation can only be made on a form prescribed by us and will only be effective when filed with us during your lifetime. Unless you 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.

Either party can terminate this Agreement at any time by giving written notice to the other. We can resign as custodian at any time effective 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 to your HSA within 30 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 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 any savings instrument or other investment in 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 as are required by forms or regulations, the IRS may after notifying you, require you to substitute another custodian or trustee.

**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 30 days from the date we mailed the amendment, you notify us in writing that you do not consent.

**Withdrawals:** All requests for withdrawal shall be in writing on a form provided by or accepted by us. 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. We reserve the right to reasonable restrict the frequency and/or minimum amount of distributions.

**Transfers from Other Plans:** We can receive amounts transferred to this HSA from the custodian or trustee of another HSA or MSA. However, we also reserve the right not to accept any transfer.

**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 to which assets to liquidate, we will decide in our complete discretion and you agree not to hold us liable for any adverse consequences that result from our decision.

**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.

**What Law Applies:** 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, any 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 either of such provisions of your or our right thereafter to enforce each and every such provision.

**Identifying Number:** The Customer's social security number will serve as the identification number of this HSA. For married persons, each spouse who is eligible to open an HSA and wants to contribute to an HSA must establish his or her own account.

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 any employer contributions to your HSA. We are not responsible for monitoring or notifying you of your employer's contributions to your HSA. You are responsible for contacting your employer regarding its contributions and monitoring those contributions. We will provide a monthly statement 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. The insurance agent or agency is not our partner, agent, affiliate, representative or co-venture.