MyHSA Complete Application
Accountholder Terms & Conditions

Introduction – This form is used to open a new MyHSA account.

You want to open a MyHSA Health Savings Account ("MyHSA") at Alliance Benefit Group of Illinois, Inc. ("Alliance"). Your participation in the MyHSA program is conditioned on your acceptance of certain terms, which are identified below. Please read carefully before proceeding. Additional information is available through certain web links identified below, or by calling the MyHSA Help Desk at 800-57 MyHSA (800-576-9472). The MyHSA program is made available pursuant to an agreement between Alliance Benefit Group of Illinois, Inc. ("Alliance") and The Charles Schwab Bank ("CSB").

USE OF ELECTRONIC RECORDS

An "electronic record" means a record created, generated, sent, communicated, received or stored by electronic means. A "record" means any information that is **inscribed on a tangible medium or stored** in an electronic or other medium and is retrievable in perceivable form.

Participation in the MyHSA program is conditioned on your agreement to have records provided or made available to you in connection with the MyHSA program in electronic form. If you do not wish to receive electronic records, you will not be able to participate.

If you consent to have records in connection with this request or this MyHSA program provided or made available in electronic form, you may withdraw that consent at any time. However, in such event Alliance Benefit Group of Illinois, Inc. has the right to terminate your participation and require that you liquidate your MyHSA account and have your funds returned to you at the address on record.

Your consent to receive records in electronic form applies to all records that may be provided or made available at any time in connection with the MyHSA program, including but not limited to account statements, transaction records, fund prospectuses and annual reports.

In order to withdraw your consent to receive electronic records or to provide updated information on how Alliance Benefit Group can contact you electronically, you must contact us by telephone at 800-57 MyHSA (800-576-9472).

IMPORTANT INFORMATION

Following is important information regarding the MyHSA program and your participation therein. Please read this information carefully. If you have any questions, you may contact us by telephone at 800-57 MyHSA (800-576-9472).

1. MyHSA Health Savings Account Custodial Agreement. You will be required to acknowledge that you have read and agree to the terms of the MyHSA Health Savings Account Custodial Agreement before you can enroll in the Program.
2. MyHSA Health Savings Account participant Fee Schedule. You will be required to acknowledge that you have read and agree to the terms of the MyHSA Health Savings Account Fee Schedule before you can enroll in the Program. Participants not making contributions through payroll deductions are required to make a minimum contribution to open an account.
3. In connection with this Program, Alliance Benefit Group of Illinois, Inc. ("Alliance"), an investment advisor registered under the Securities Exchange Act of 1934, is providing certain administrative and record keeping services for the MyHSA program and is responsible for the selection of the investment options ("Investment Options") available through the Program.
4. Alliance's Investment Policy Statement. You will be required to acknowledge that you have read the Investment Policy Statement before you can enroll in the Program.
5. Alliance's Privacy Policy with respect to use of your personal information. You will be required to acknowledge that you have read the Privacy Policy before you can enroll in the Program.
6. Through an agreement between Alliance and The Charles Schwab Bank ("CSB"), CSB (or CSB through a broker/dealer) will execute transactions in the Investment Options. CSB may use the services of a broker/dealer that is an affiliate of CSB.
7. Although Alliance receives certain fees from the Funds, these fees do not affect Alliance's process in selecting and making such Funds available as Investment Options.
8. You may view or download a copy of the full prospectus for any of the Investment Options at www.myhsa.com. Before you enroll, you will be required to acknowledge that you have received and read the prospectuses or prospectus profiles relating to the applicable Investment Options.
9. The assets you invest may be aggregated by CSB in applicable custodial accounts for investment purposes with the assets of other participants participating in the MyHSA program.
10. Both Alliance and CSB will receive payments, which are sometimes referred to as "revenue sharing", from the investment adviser or sponsor of the Funds for certain plan expenses or otherwise for the benefit of you and your beneficiaries.
    a. the amount of such payments is based on a number of factors, including the level or type of services provided, the level or expected level of assets or sales of shares, and the placing of the Funds on a preferred or recommended fund list;

b. these types of payments are made by the investment adviser or sponsor of the Funds to many different intermediaries, including some of the largest broker-dealers and other financial firms;
c. these payments may be significant, but are consistent with applicable laws and regulations; and
d. these additional payments may represent a premium over payments made by the investment adviser or sponsor of other fund families, and investment professionals may have an added incentive to sell or recommend a fund or a share class over others offered by competing fund families.

11. Until you submit instructions to Alliance regarding your choice of Investment Options (the "Investment Allocations"), any funds contributions to CSB will be invested by CSB in a default fund ("Default Fund"). Any funds placed into the Default Fund will not be invested in accordance with the Investment Allocations until you expressly instruct Alliance otherwise.
12. You may access statements reflecting your MyHSA account information at any time from the Alliance website or, in the alternative, you may request a paper statement from Alliance. Although you will not receive confirmations for each individual order that you place, information concerning your orders will be available within 24 hours on the Alliance website.
13. You must provide Alliance with an irrevocable proxy to vote all applicable Fund proxies on your behalf. All such proxies will be voted in favor of, or as recommended by, the board of directors of the respective company or Fund issuing such proxies.

ACKNOWLEDGMENT AND CONSENT

You hereby acknowledge that you have read and understood the above captioned "IMPORTANT INFORMATION" and agree to its terms, including but not limited to the following specific provisions:
You consent to transacting electronically for all matters relating to this Program, including the receipt of statements, prospectuses, and notices by email or posting directly or through a link on the designated Alliance website, and you understand that you are foregoing your right or option to transact in paper or non-electronic form. You acknowledge that you may withdraw your consent to transact electronically, but understand that such withdrawal may terminate your eligibility to participate in the investment Program.
You have read the **Alliance Custodial Agreement**.
You have read the **Alliance Investment Policy Statement**.
You have read the **Alliance Privacy Policy**.
You have read and understand the **Alliance MyHSA Fee Schedule**.
You have received and read the prospectuses or prospectus profiles of the applicable **Investment Options**.
You grant an irrevocable proxy to Alliance to vote all applicable Fund proxies on your behalf.

All forms are available on www.myhsa.com.

I have read and agree to the terms of the ABG MyHSA Health Savings Account YES ☐

First Name: _____

Middle Initial: _____

Last Name: _____

Social Security Number: _____

Signature of Account Holder: _____ Date**:** _____

Broker ID: _____
(if applicable)

APPLICATION & BENEFICIARY DESIGNATION FORM

(PLEASE PRINT)

Please complete this Application & Beneficiary Designation Form for the Alliance Benefit Group (ABG) Health Savings Account Program and see return instructions on the next page.

ACCOUNT HOLDER INFORMATION		
Name: (First):	**(MI):**	**(Last):**
Social Security Number:	**Date of Birth:**	
Mailing Address:		
City:	**State:**	**Zip:**
Home Phone Number:	**Work Phone Number:**	
Email Address:		
HSA Qualified Health Plan Effective Date:		

EMPLOYER INFORMATION		
Employer Name:		
Address:		
City:	**State:**	**Zip:**

Eligibility Acknowledgement (you must check yes on the question below to be eligible for a Health Savings Account. If you answered no, please see your Benefits Administrator for more details)

☐ **Yes** ☐ **No** **I am currently an eligible individual as described in the Custodial Agreement into which this Application is incorporated. I understand that maintaining my eligibility is my responsibility and that Alliance Benefit Group and The Charles Schwab Bank assumes that all contributions are made while I am eligible to participant in a qualified Health Savings Account.**

ADOPTION AGREEMENT

This application is for the establishment of my individually owned Health Saving Account. I understand that by signing this Application, I am acknowledging that I have received and reviewed the Alliance Benefit Group Health Savings Account Custodial Agreement and agree to be bound by the terms of this agreement. In accordance with the terms and conditions of this agreement, I am requesting Alliance Benefit Group to establish a Health Savings Account on my behalf with The Charles Schwab Bank as Custodian. I further understand and acknowledge that my Health Savings Account is not effective until it has been accepted by Alliance Benefit Group. **I acknowledge that all contributions eligible for investment (as defined within the Alliance Benefit Group Health Savings Account Individual Custodial Agreement) will be invested in a MetLife Guaranteed Fund until I have logged in to my account and set my contribution investment elections**. The information on this application is true and accurate to the best of my knowledge and I submit this form with full understanding and acceptance of the provisions contained within the Custodial Agreement. I also acknowledge that Alliance Benefit Group is authorized to perform transactions on my account and all such transactions initiated by Alliance Benefit Group should be treated as if initiated directly by me, the Account Holder.

Signature of Account Holder: _____ Date: _____

Alliance Benefit Group of Illinois, 456 Fulton Street, Suite 345, Attn: MyHSA Peoria, Il 61550
Help Desk at 1-800-576-9472 Monday-Friday 7:30 am to 5:00 pm CT **Fax** 1-800-688-4329

MyHSA Beneficiary Designation Form

ACCOUNT HOLDER INFORMATION		
Name: (First):	**(MI):**	**(Last):**
Social Security Number:	**Daytime Phone Number:**	
Mailing Address:		
City:	**State:**	**Zip:**
Email Address:		

Designation of Beneficiary (ies) – Please Print

I hereby revoke any Designation of Beneficiary I may previously have made in writing and or in electronic format.

Please list your primary and/or secondary beneficiary (ies), and the percentage of your account, which you would like each beneficiary to receive. If more than one beneficiary of a class is designated and no distribution percentages are identified, the beneficiaries will be deemed to own equal shares in the account. If you have designated a Trust as beneficiary, the entire benefit will be paid to the Trust (unless different percentages are designated. If you do not designate a beneficiary your entire benefit will be paid to your Estate. If any primary or secondary beneficiary dies before you do, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining beneficiaries shall be increased on a pro rata basis. If no primary beneficiary survives you, the secondary beneficiary (ies) shall acquire the designated share of your account. Completion of this form will supersede all prior designations. I understand that I may change or add beneficiaries at any time by completing and delivering the proper electronic or paper form to Alliance Benefit Group of IL.

PRIMARY BENEFICIARY (IES) – Shares must equal 100%

Name _____ Name _____

Relationship _____ Relationship _____

Social Security Number _____ Social Security Number _____

Mailing Address _____ Mailing Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Percentage _____% Phone # _____ Percentage _____% Phone # _____

SECONDARY BENEFICIARY (IES) – Shares must equal 100%

Name _____ Name _____

Relationship _____ Relationship _____

Social Security Number _____ Social Security Number _____

Mailing Address _____ Mailing Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Percentage _____% Phone # _____ Percentage _____% Phone # _____

Spousal Consent: For Account Holders in Community Property or Marital Property States

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 on this application. 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 acquire 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.

X _____ **X** _____

Signature of Spouse Date Signature of Witness Date

Account Holder Authorization

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

1. This designation is subject to all the terms and provisions listed above, and shall be effective only if received by Alliance Benefit Group of IL prior to the death of the named MyHSA account holder listed above.
2. This designation applies to the account holder's entire interest, in the account at the account holder's death.
3. I agree that the above information correctly reflects my desire to add or change death beneficiaries on my MyHSA Health Savings Account.

X _____ _____

Signature of Account Holder Date

MyHSA CONTRIBUTION AUTHORIZATION FORM

(PLEASE PRINT)

(Funds must be received prior to April 15th to qualify as a previous year contribution)
If you do not enter a contribution year below, your contribution will be processed in the year that we receive your form.

ACCOUNT HOLDER INFORMATION		
Name: (First):	**(MI):**	**(Last):**
Social Security Number:	**Daytime Phone Number:**	
Mailing Address:		
City:	**State:**	**Zip:**
Email Address:		

Contribution

Contribution is for calendar year ending:_____ **Contribution amount:**_____

If no calendar year ending year is entered above or if this form is received after the tax year deadline your contribution will be applied to the current tax year.

This contribution is via (check one):

☐ **Check by mail** Please make check payable to *Charles Schwab Bank*
On the check write "FBO #201892"
Mail (with form) to the address below

☐ **ACH Pull Initiated by Alliance Benefit Group of Illinois** (complete the banking information below)

****You must attach a copy of a voided check****

_____ **Name of Financial Institution**

_____ **Routing and Transit Number (9 Digits)**

(Authorization applies to checking accounts only)

_____ **Account Number**

I hereby authorize Alliance Benefit Group (ABG) to initiate and adjust a ONE TIME electronic transaction from the bank account named above to my ABG MyHSA account. These transactions are made through regional automated clearing house (ACH) associations and are subject to the operating rules and regulations of the National Automated Clearinghouse Association (NACHA).

All MyHSA account holders are responsible for assuring there are sufficient funds available in their account at the time of withdrawal. Where applicable, returned checks and ACH returns will incur additional fees. I certify that I am the owner of the account named above and that I have the legal right to provide this authorization.

MyHSA Account Holder Signature: _____ Date: _____

MAIL OR FAX A COPY OF THIS FORM TO:
ALLIANCE BENEFIT GROUP OF ILLINOIS
MyHSA DEPARTMENT
456 FULTON STREET, SUITE 345
PEORIA, IL 61602
FAX (800) 688-4329

If you have any questions please call 800-57MyHSA (800-576-9472).

ELECTRONIC FUNDS TRANSFER (EFT)
CONTRIBUTION AUTHORIZATION FORM

(PLEASE PRINT)

Complete this form only if you wish Alliance Benefit Group of Illinois to initiate an electronic funds transfer (EFT) withdrawal from your personal bank account for purpose of MyHSA contribution on an ongoing MONTHY basis.

ACCOUNT HOLDER INFORMATION		
Name: (First):	**(MI):**	**(Last):**
Social Security Number:	**Daytime Phone Number:**	
Mailing Address:		
City:	**State:**	**Zip:**
Email Address:		

I am completing this form for the purpose of: (check all that apply)

- ☐ Creating a **NEW** monthly EFT
- ☐ Changing the amount of a current EFT
- ☐ Changing the financial institution of a current EFT
- ☐ Changing the contribution date of a current EFT
- ☐ **DISCONTINUING** a current EFT

☐ Check here if you would also like the bank account information below used for **direct deposit** of claims

I understand that contributions to my HSA account can not exceed the maximum statutory limits (for more information on these limits go to www.myhsa.com or call our help desk at 800-576-9472). I understand that trying to contribute more than the allowed maximum contribution to my HSA account could result in additional fees and tax penalties.

I hereby authorize Alliance Benefit Group (ABG) to initiate and adjust MONTHLY electronic transactions from the bank account named below to my ABG MyHSA account. These transactions are made through regional automated clearing house (ACH) associations and are subject to the operating rules and regulations of the National Automated Clearinghouse Association (NACHA).

I understand this change will not be effective until the third business day following receipt of the completed form by Alliance Benefit Group of Illinois. All MyHSA account holders are responsible for assuring there are sufficient funds available in their account at the time of withdrawal. Where applicable, ACH returns will incur additional fees.

Please complete the appropriate sections (for a new EFT, complete all):

_____
Name of Financial Institution

_____
Routing and Transit Number (9 Digits)

_____
Account Number ***(Authorization applies to checking accounts only)***

Contribution Amount: $_____

Contribution Date: (select one)

☐ **1st Business Day of each Month**

☐ **15th Business Day of each Month**

Start Date _____

I certify that I am the owner of the account named above and that I have the legal right to provide this authorization. This authorization remains in full force and effect until which time Alliance Benefit Group has received written notification from me of its termination. Termination notification must be received at least ten (10) business days prior to your next ACH contribution.

Signature of Account Holder: _____ **Date:** _____

For New Bank Information: **A COPY OF A VOIDED CHECK MUST BE ATTACHED**

MAIL OR FAX A COPY OF THIS FORM TO:

ALLIANCE BENEFIT GROUP OF ILLINOIS
MyHSA DEPARTMENT
456 FULTON STREET, SUITE 345
PEORIA, IL 61602

FAX (800) 688-4329

If you have any questions please call 800-57MyHSA (800-576-9472).

AUTHORIZATION FOR DIRECT DEPOSIT (EFT)
CLAIM/DISTRIBUTION PROCESSING (OPTIONAL)

(PLEASE PRINT)

Complete this form only if you wish Alliance Benefit Group of Illinois to initiate a direct deposit/electronic funds transfer (EFT) when reimbursing for a qualified medical expense paid out-of-pocket.

ACCOUNT HOLDER INFORMATION		
Name: (First):	**(MI):**	**(Last):**
Social Security Number:	**Daytime Phone Number:**	
Mailing Address:		
City:	**State:**	**Zip:**
Email Address:		

I hereby authorize Alliance Benefit Group (ABG) as program administrator to initiate credit entries as direct deposit claim reimbursements and to initiate, if necessary, debit adjustment entries made for any credit entry made in error to my account. These transactions are made through regional automated clearing house (ACH) associations and are subject to the operating rules and regulations of the National Automated Clearinghouse Association (NACHA).

I understand this change will not be effective until the third business day following receipt of the completed form by Alliance Benefit Group of Illinois. Where applicable, ACH returns will incur additional fees.

Please complete the appropriate sections (for new EFT, complete all):

_____
Name of Financial Institution

_____
Routing and Transit Number (9 Digits)

_____
Account Number *(Authorization applies to checking accounts only)*

I certify that I am the owner of the account named above and that I have the legal right to provide this authorization. This authority shall apply to all requests for claim reimbursements I submit to ABG under the Health Savings Account program. This authorization remains in full force and effect until which time ABG has received written notification from me of its termination. I agree to provide such notification of cancellation in such a manner as to afford Alliance Benefit Group reasonable time to act on it. Failure to notify ABG in a timely manner could result in additional fees.

Signature of Account Holder: _____ **Date:** _____

****A COPY OF A VOIDED CHECK MUST BE ATTACHED****

MAIL OR FAX A COPY OF THIS FORM TO:

ALLIANCE BENEFIT GROUP OF ILLINOIS
MyHSA DEPARTMENT
456 FULTON STREET, SUITE 345
PEORIA, IL 61602

FAX (800) 688-4329

If you have any questions please call 800-57MyHSA (800-576-9472).