



Please review and complete the following enrollment form. If you have any questions please contact MSAver Resources L.L.C. at 866-889-8581 Please mail to: **MSAver Resources P.O. Box 26106 Shawnee Mission, KS 66225**

Individual Information

Title: Mr. Mrs. Ms. Dr. **Social Security Number (Must be 9 digits):** _____ - _____ - _____

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

Date of Birth: ____/____/____ **Farm Bureau Member #:** _____ **County of Memberhip:** _____

Physical Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Telephone (Work): _____ **Telephone (Home):** _____

Fax: _____ **E-mail:** _____ **Drivers License #:** _____ **Sate:** _____

Insurance Information

Carrier Name: _____ **Agent Name:** _____

Bank Referral #: _____ **Telephone:** _____

Effective date of my qualified, high-deductible health plan: ____/____/____

Deductible Amount: Single: Minimum \$1,000 / out-of-pocket limit \$5,000 maximum
 Family: Minimum \$2,000 / out-of-pocket limit \$10,000 maximum

PARTICIPANTS IN AN HSA CANNOT BE COVERED BY ANOTHER HEALTH PLAN EXCEPT "PERMITTED" INSURANCE PRODUCTS.

Beneficiary Designation

I hereby certify that if I die before distribution has been completed, the value of my account shall be distributed to the person(s) named below:

| Primary Beneficiary(ies) Name | Address | Relationship | Tax ID# | Date of Birth | Percentage Must total 100% |
|----------------------------------|---------|--------------|---------|---------------|-------------------------------|
| | | | | | |
| | | | | | |

| Secondary Beneficiary(ies) Name | Address | Relationship | Tax ID# | Date of Birth | Percentage Must total 100% |
|------------------------------------|---------|--------------|---------|---------------|-------------------------------|
| | | | | | |
| | | | | | |

The funds remaining in the HSA at my death shall be paid in the percentages indicated above (or in equal shares if no percentages are provided) to the Primary Beneficiaries who survive me. If the Primary Beneficiary predeceases me, the interest of a deceased Primary Beneficiary shall terminate and the percentage share of any surviving Primary Beneficiary(ies) shall increase on a pro rata basis. If no Primary Beneficiary survives me, the payment shall be paid in the percentages indicated above (or in equal shares if no percentages are provided) to the Secondary Beneficiaries who survive me. If a Secondary Beneficiary predeceases me, the interest of the deceased Secondary Beneficiary shall terminate and the percentage share of any surviving Secondary Beneficiary(ies) shall increase on a pro rata basis. If my spouse receives the HSA as a result of being named as Beneficiary, my spouse may choose to continue the HSA in his or her name by providing a written election to the Custodian. For any non-spouse Beneficiary, the HSA terminates as of my date of death and becomes payable. If no Beneficiaries are named on this form or if all of the named Beneficiaries predecease me, the HSA funds will be paid to my estate. I may change the Designation of Beneficiaries by filing a new Beneficiary Designation in a written form acceptable to the Custodian prior to my death. I understand that in certain states my spouse's consent may be necessary if I wish to name a person other than, or in addition to, my spouse as Beneficiary, and that I should consult with my attorney before making such a Beneficiary Designation. By making the foregoing Beneficiary Designation, I represent and warrant to the Custodian that said Beneficiary Designation satisfies all legal requirements under applicable law and, on behalf of myself, my heirs and my estate, I hereby indemnify and hold the Custodian harmless from and against any and all claims, damages, liabilities, and costs (including attorney's fees) arising as a result of the Custodian's payment of my HSA in accordance with the foregoing Beneficiary Designation.

Contributions

Please use the following formula to figure the maximum annual contribution allowed for your HSA account.

Health insurance deductible (a) \$ _____
 Maximum annual contribution amount (a) x 100% if single coverage not to exceed \$2,600 (b) \$ _____
 Maximum annual contribution amount (a) x 100% if family coverage not to exceed \$5,150 (c) \$ _____
 Monthly Contribution Amount (b or c) divided by 12 (d) \$ _____
 Pro-rated annual contribution based on the effective date of health plan (e) \$ _____
 Computation: Number of full months covered by HSA plan x (c)

Note: I understand that I may only take a tax deduction on HSA contributions for months in which I was covered by a high-deductible health plan on the first day of the month. Total tax deductible contributions must be credited to account by April 15 of the following calendar year.

Account Access

If this application is accepted an HSA VISA® Checkcard and checks are issued, one Checkcard will be issued to the name shown under Individual Information. If additional signers are desired, indicate each authorized signer's name and provide their individual signature below. I understand that the issuance of an HSA VISA® Checkcard(s) is within Farm Bureau Bank FSB's sole discretion and may be contingent upon a credit check. I agree that my HSA VISA® Checkcard will be governed by the Cardholder Agreement sent to me. There is a fee for each additional card requested.

| | | Additional HSA Card Yes / No | |
|----------------------------|------------|---------------------------------|--|
| Name of additional signer: | Signature: | | |
| Name of additional signer: | Signature: | | |

E-Option

Yes, I would like **E-Option** (Internet Access Required).

With the **E-Option** you will receive account information on-line and **earn a higher yield**. With the **E-Option**, statements will not be mailed.

Administration Fee and Initial HSA Deposit

Administration fee There is no cost of open your Health Savings Account. The administration fee is \$4.15 per month after the first year. This amount will be electronically withdrawn from your HSA account.

Minimum Initial Deposit is \$100.00 (Make Initial Deposit check payable to Farm Bureau Bank FSB)

Initial HSA Deposit: \$ _____ (for tax year 20 _____)

Initial deposit made by: Employer \$ _____ Individual \$ _____

Is this a rollover? Yes No Amount of rollover contribution: \$ _____

In the case of a rollover, I certify that this contribution is a rollover contribution within the meaning of IRS Section 223, that the rollover is being made within 60 days of receipt and I have not received a rollover in the last 12 months.

Method of Contributions

Yes, I would like to use electronic funding of my HSA. Please see disclosure below.

As a convenience to me, I hereby request and authorize you to charge to my account, pre-authorized checks and electronic debits or to credit pre-authorized deposits and electronic credits originated by Farm Bureau Bank FSB and MSAver Resources L.L.C. I agree that your rights in respect to each debit/credit transaction shall be the same as if it were a transaction originated personally by me.

This authority shall remain in effect until you are notified otherwise in writing and you shall be fully protected in honoring any such entry until actually receiving such notice. I further agree that if you dishonor or fail to make any such entry, whether with or without cause and whether intentionally or by mistake, you shall be under no liability whatsoever.

Please specify the dollar amount that you wish to be transferred: \$ _____. Please indicate the day of the month you would like funds to be transferred _____. You must include a voided check from the account that you wish your contributions to be deducted from.

No, I would prefer to mail in additional deposits to my account.

Farm Bureau Bank FSB Adoption Agreement

Under penalties of perjury, I certify that the information set forth on this form above (including my Social Security Number) is correct. By signing below, I agree to participate in the MSAver Health Savings Account ("MSAver HSA") plan offered by Farm Bureau Bank FSB and I acknowledge receipt of the Farm Bureau Bank FSB Health Savings Account Disclosure Statement and Farm Bureau Bank FSB Health Savings Account Custodial Agreement. I agree to be bound by all of the terms and conditions contained in said Disclosure Statement and Custodial Agreement as they may be amended from time to time, as well as any rules or other terms subsequently issued by Farm Bureau Bank FSB in connection with the MSAver HSA plan, and I direct that all funds remaining in any MSAver HSA at my death will be paid to the Beneficiaries as I have designated elsewhere on this form. Further, I understand that this Enrollment Form and Adoption Agreement is subject to acceptance by Farm Bureau Bank FSB. I understand that I will be subject to the MSAver Deposit Account Terms and Conditions which will be provided to me by Farm Bureau Bank FSB when my MSAver HSA deposit account is opened. I agree to pay all fees applicable to my MSAver HSA and authorize Farm Bureau Bank FSB to deduct such fees from my MSAver HSA. I acknowledge and agree that (i) only Farm Bureau Bank FSB is responsible for providing HSA account services to me, (ii) neither MSAver Resources L.L.C. nor its Marketing Representative shall have any liability to provide, and will not provide, any such account services, (iii) any administrative services described in the Section below provided to me will be provided solely by MSAver Resources L.L.C. separate and apart from the account services provided by Farm Bureau Bank FSB, and (iv) neither Farm Bureau Bank FSB nor MSAver Resources L.L.C. have any control over, or liability for, each other or the respective services that each provides. Any agency, appointment or authority that I may give to MSAver Resources L.L.C. or to anyone else (including any that may be set forth in the Section below or in any other portion of this document) shall not apply to any MSAver HSA or other account established at or by Farm Bureau Bank FSB, and I agree that Farm Bureau Bank FSB shall have no duty to act upon any directions of anyone claiming to act as my agent or representative. I agree that Farm Bureau Bank FSB need not honor or act upon any order, instruction, or other action or writing of MSAver Resources L.L.C. or any other person or entity purportedly acting as my agent or representative, whether to transfer my account or funds, take any other action on or to my account, or otherwise. I agree that Farm Bureau Bank FSB may require, as a condition of each transfer or requested action by it, that it first receive specific written instructions signed by me. Under penalty of perjury, I/We certify that: (1) The number shown on this form is my correct Social Security Number and (2) I am not subject to backup withholding either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest and dividends or the IRS has notified me that I am no longer subject to backup withholding. I am a U.S. person (including a U.S. resident alien). Cross out and initial statement #2 if you have notified that you are subject to backup withholding. (3) I/We understand that my/our account is bound by the terms and conditions specified in the Deposit Account Agreement and disclosures that will be sent to me upon opening of my account. My signature authorizes Farm Bureau Bank FSB to open the account I have indicated above. 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 drivers license or other identifying documents.

Customer

Farm Bureau Bank FSB

By : _____

By: _____

MSAver Resources L.L.C. Customer Agreement

The following administrative services for my MSAver Health Savings Account ("MSAver HSA") are provided to me solely by MSAver Resources L.L.C.: enrollment assistance and documents which may be provided through the Marketing Representative, and access to the toll-free tax assistance help-line to answer any questions concerning Health Savings Accounts, tax-related matters, qualified medical expenses, or other distributions. In consideration for these administrative services, I agree to pay MSAver Resources L.L.C. the administration fee by means of electronic withdrawal. In the event that my monthly fee is unpaid for a period of 60 days, MSAver Resources, L.L.C. reserves the right to close my account and retain whatever fees are in the account to offset unpaid fees. I understand and agree that Farm Bureau Bank FSB has no control over such administrative services and no obligation or liability with respect to administrative services. I acknowledge that MSAver does not provide investment advice and that all investment decisions and instructions regarding my MSAver Health Savings Account will be made solely by me upon consultation with my personal broker or investment advisor. I hereby appoint and authorize MSAver Resources L.L.C. as my designated agent to, with prior notice to me, transfer my MSAver HSA to another trustee or custodian, other than the initial depository bank designated by MSAver Resources L.L.C. who will provide comparable or superior service, including a custodian who is affiliated with MSAver Resources L.L.C. This appointment of MSAver Resources L.L.C. as my designated agent is effective as of the date shown on the signature page of this form until revoked by me in writing. I have read and consent and agree to the terms of the MSAver Customer Agreement described above.

Customer

MSAver Resources L.L.C.

By : _____

By: _____

Fee Schedule

MSAver Health Savings Account Administration Fee (services include):

Account Services:

- 1) Periodic MSAver Health Savings Account statements showing activity in the account. This would include, but not be limited to contributions received, withdrawals from the account, interest earned and any other appropriate information concerning your account.
- 2) IRS Forms 1099-HSA and other reports of the Custodian as required by the IRS.

Administrative Services:

- 1) Continued access to the toll-free tax assistance help line to answer any questions you might have concerning Health Savings Accounts, qualified medical expenses, or other tax-related matters.

Additional Fees: Account and Administrative fees will be automatically debited from your MSAver Health Savings Account. Prices subject to change with 30 days notice.