This PDF can be filled out on your computer before printing

HSA INFORMATION CHECK LIST

The information below is required by the USA PATRIOT ACT. **We cannot open your account without it.** Please complete all fields on the Health Savings Account Application and provide:

- ☐ Full Legal Name (First, Middle Initial, Last)
- ☐ Date of Birth
- ☐ Social Security Number
- ☐ Copy of **current** Driver's License, Passport, Military or State I.D. (Cannot be expired)
- ☐ *Include all of the information above if you have designated an individual as an Authorized Signer in section #5*
- ☐ **Street Address** (P. O. Box not valid[1]).
  Proof of address is required if current address does not match address on I.D. (examples include a copy of: current utility, electric, or medical bill listing your name and current address.) [1]*If you receive mail at a P.O. Box please supply us with both your Street Address and P.O. Box.*
- ☐ **Sign** and **date** the application. *Authorized Signers signature is required (If you have designated an individual in section #5)*
- ☐ Include a **$50 check or money order** payable to Bank of Cashton ($50 *Minimum* Deposit to open)
- ☐ Mail everything above including any additional forms (e.g. HSA Transfer Request Form) to:

Bank of Cashton
PO Box 70
Cashton, WI 54619

BANK OF CASHTON
Since 1899

(800) 205-7203

www.bankofcashton.com

HEALTH SAVINGS ACCOUNT (HSA) APPLICATION

BANK OF CASHTON Since 1899

BANK OF CASHTON
PO BOX 70
CASHTON, WI 54619
(800) 205-7203

1 HSA OWNER INFORMATION

WWW.BANKOFCASHTON.COM

FULL NAME (FIRST, M.I., LAST)			HSA ACCOUNT NUMBER	
STREET ADDRESS	MAILING ADDRESS (IF DIFFERENT)		SOCIAL SECURITY NUMBER (SSN)	
CITY, STATE, ZIP	CITY, STATE, ZIP (IF DIFFERENT)		EMAIL ADDRESS	
HOME PHONE NUMBER	WORK PHONE NUMBER	CELL PHONE NUMBER	DATE OF BIRTH	GENDER
				☐ MALE ☐ FEMALE
EMPLOYER	DRIVERS LICENSE NUMBER		DL STATE	HEALTH INSURANCE TYPE
				☐ SINGLE ☐ FAMILY

2 CONTRIBUTION INFORMATION

TAX YEAR	AMOUNT	CONTRIBUTION DATE

CONTRIBUTION TYPE (SELECT ALL THAT APPLY):

- ☐ Regular
- ☐ Rollover from an HSA
- ☐ Transfer from an HSA (Complete Transfer Request Form)
- ☐ Catch-Up (age 55 or older and not enrolled in Medicare)
- ☐ Contribution from an IRA
- ☐ Return of Mistaken Distribution

3 DESIGNATION OF BENEFICIARY

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.

A. PRIMARY BENEFICIARY

PERCENTAGE	NAME OF BENEFICIARY	SSN OR TAXPAYER IDENTIFICATION NUMBER	DATE OF BIRTH	RELATIONSHIP TO HSA OWNER
%				
%				
%				
TOTAL 100%				

B. CONTINGENT BENEFICIARY

PERCENTAGE	NAME OF BENEFICIARY	SSN OR TAXPAYER IDENTIFICATION NUMBER	DATE OF BIRTH	RELATIONSHIP TO HSA OWNER
%				
%				
%				
TOTAL 100%				

4 SPOUSAL CONSENT

_____ (HSA Owner Initials) **I Am Married**. I understand that if I designate a primary beneficiary other than my spouse, my spouse must consent by signing below.

_____ (HSA Owner Initials) **I Am Not Married**. I understand that if I marry in the future, I must complete a new Designation of Beneficiary form, which includes the spousal consent documentation.

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 Section 3 of this form.

X _____ Signature of Spouse _____ Date

X N/A Signature of Witness (if required) _____ Date

5 AUTHORIZED SIGNER (OPTIONAL)

Since regulations require that only one individual own the HSA Account, the account holder may want their spouse and or another third party to have the ability to access this HSA. I (account holder) hereby designate the following individual as an additional authorized signer on my Health Savings Account.

FULL NAME (FIRST, M.I., LAST)			SOCIAL SECURITY NUMBER (SSN)	
STREET ADDRESS	MAILING ADDRESS (IF DIFFERENT)		EMAIL ADDRESS	
CITY, STATE, ZIP	CITY, STATE, ZIP (IF DIFFERENT)		DRIVERS LICENSE NUMBER	STATE
HOME PHONE NUMBER	WORK PHONE NUMBER	CELL PHONE NUMBER	DATE OF BIRTH	GENDER
				☐ MALE ☐ FEMALE

6 SIGNATURES

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. I certify that the information provided by me on this Application is accurate, and that I have received either in print or electronically, read and agree to be bound by the terms and conditions found in the Application, Account Agreement, Health Savings Custodial Account, IRS Form 5305-C, HSA Account Disclosures (available anytime at https://www.bankofcashton.com/forms or by calling 800.205.7203) and any amendments thereto. I assume sole responsibility for all consequences relating to my actions concerning this HSA. I have not received any tax or legal advice from the Bank of Cashton, 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 Bank of Cashton harmless against any and all claims or losses arising from my actions. I acknowledge that the information provided is subject to Bank of Cashton's Bank's Privacy Policy but limited information may be shared with HSA vendors and consultants, your insurance agent and your employer. All signers authorize the Bank of Cashton to make inquiries from any consumer reporting agency, including a check protection service, in connection with this 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 to you: When you open an account we will need you and your authorized signer to provide name, address, date of birth and other information that will allow us to identify you and your authorized signer.

TAXPAYER IDENTIFICATION NUMBER (T.I.N.) CERTIFICATION

Under penalties of perjury, I certify (**1**) that the number shown is my correct taxpayer ID number or social security number, (**2**) that I am a U.S. person (including U.S. resident alien), (**3**) and that I am not subject to backup withholding because (a) I am exempt from backup withholding or (b) because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends or (c) because the IRS has notified me that I am no longer subject to backup withholding. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding. You must cross out item **3** above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

HSA OWNER SOCIAL SECURITY NUMBER (SSN)

7 HSA ACCOUNT OPTIONS (please check only one box)

- ☐ I would like a FREE Visa® debit card issued in my name for my HSA account (See Page 5).
- ☐ I would like two FREE Visa® debit cards, one issued in my name and a second issued for the POA listed above (See Page 5).
- ☐ I would like to order (25) FREE duplicate checks.
- ☐ I would like **both** the Visa® debit card(s) and (75) duplicate checks. **Cost for this option is $8.25**.

8 STATEMENT OPTIONS (please check only one box)

- ☐ I would like to receive my statements electronically and agree to the "e-statement consent and online agreement" below.
- ☐ I would like to receive my statements via the US postal service in paper format.

X _____
Signature of HSA Owner **Date**

X _____
Signature of Authorized Signer **Date**
(Person Designated in Section #5)

HOW DID YOU HEAR ABOUT THE BANK OF CASHTON?

_____

X _____ For Internal Use _____
Signature of Custodian **Date**

E-STATEMENT CONSENT AND ONLINE AGREEMENT

The terms "you" and "your" refer to the depositor (whether single or multiple party) and the terms "we," "us" and "our" refer to Bank of Cashton. Upon receipt of your consent to the terms of this eStatement Consent ("Agreement") you agree that all disclosures, statements, records, notices and other information including any changes, additions, or deletions to the terms of your Deposit Account Agreement or to other products or services covered by this Agreement (including, but not limited to, any required legal notices) may, at Bank of Cashton option, be provided or otherwise made available in electronic format. By accepting electronic delivery of disclosures, statements, records, notices, and other information, products or services, you also agree that Bank of Cashton will no longer provide you with paper versions of the documents covered by this Agreement either now or in the future. You must be enrolled in Online Banking to receive the services covered under this Agreement. You must notify us within sixty (60) days after we email the statement notification to you of any discrepancies. If you fail to notify us, you will have no claim against us. However, if the discrepancy is the result of an electronic fund transfer, the provisions of our Disclosures will control its resolution. If you do not receive a statement notification from us because you have failed to supply us with a correct email address or if your electronic mail is returned as undeliverable an attempt will be made to contact you. If contact cannot be made, a paper copy of your statement will be sent by U.S. mail to the last known postal address. Bank of Cashton will send an electronic alert to the email address provided by you. This email will notify you that electronic disclosures, statements, records, notices, and other information is available to view via your online banking. Sign on to Bank of Cashton Online Banking website at www.bankofcashton.com and click on the account from the "Account List" and then click on "Online Statements". From here you can choose the month in which you want to view the statement and any disclosures accompanying the statement. Statements will be available for ten (10) years. To update your email address you must log onto Bank of Cashton Online Banking and click on "Change Email" under "User Settings". You are responsible for retaining copies of any statements and disclosures. After enrollment, we will continue to make your periodic statements available for you to view. We have the right to withdraw your consent for electronic documents covered by this Agreement. You have the right to withdraw your consent to receive electronic periodic statements at any time. To withdraw your consent to receive electronic statements, you must notify us in writing to Bank of Cashton, PO Box 70, Cashton, WI 54619. The withdrawal of your consent should be received at least ten (10) days before the end of your normal statement cycle. All electronic statements shall be in full compliance with applicable laws and regulations. The provisions in this Agreement are part of (and in supplement to Bank of Cashton's Deposit Account Agreement) and are subject to all the provisions in the Terms and Conditions for our Deposit Accounts. Each Bank of Cashton account that you designate to be included within the eStatement service is also governed by the terms and conditions otherwise applicable to that kind of account as separately disclosed to you, either in the Disclosures given to you at the opening of the account or in applications and enrollment forms, the fee schedules, credit or deposit agreements, our Privacy Policy or other written disclosures.

I have read and agree to the terms of the eStatement Consent and Online Agreement above and I would like to receive eStatement delivery. I understand that I will no longer receive a periodic statement sent by U.S. Mail.

Form **5305-C**
(Rev. October 2016)
Department of the Treasury
Internal Revenue Service

Health Savings Custodial Account

(Under section 223(a) of the Internal Revenue Code)

Do not file with the Internal Revenue Service

Name of account owner	Date of birth of account owner

Address of account owner (Street address, city, state, ZIP code)

Name of custodian	Address or principal place of business of custodian
Bank of Cashton	723 Main Street, Cashton, WI 54619

The account owner named above is establishing this health savings account (HSA) exclusively for the purpose of paying or reimbursing qualified medical expenses of the account owner, his or her spouse, and dependents. The account owner 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.

$ N/A dollars in cash is assigned to this custodial account.

The account owner and the custodian make the following agreement:

Article I

1. 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). No contributions will be accepted by the custodian for any account owner that exceeds the maximum amount for family coverage plus the catch-up contribution.
2. 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).
3. 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.
4. Qualified HSA distributions from a health flexible spending arrangement or health reimbursement arrangement must be completed in a trustee-to-trustee transfer and are not subject to the maximum annual contribution limit set forth in Article II.
5. Qualified HSA funding distributions from an individual retirement account must be completed in a trustee-to-trustee transfer and are subject to the maximum annual contribution limit set forth in Article II.

Article II

1. For calendar year 2011, the maximum annual contribution limit for an account owner with single coverage is $3,050. This amount increases to $3,100 in 2012. For calendar year 2011, the maximum annual contribution limit for an account owner with family coverage is $6,150. This amount increases to $6,250 in 2012. These limits are subject to cost-of-living adjustments after 2012.
2. Contributions to Archer MSAs or other HSAs count toward the maximum annual contribution limit to this HSA.
3. For calendar year 2009 and later years, an additional $1,000 catch-up contribution may be made for an account owner who is at least age 55 or older and not enrolled in Medicare.
4. 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.

Article III

It is the responsibility of the account owner 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 account owner shall notify the custodian that there exist excess contributions to the HSA. It is the responsibility of the account owner to request the withdrawal of the excess contribution and any net income attributable to such excess contribution.

Article IV

The account owner's interest in the balance in this custodial account is nonforfeitable.

Article V

1. 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).
2. The assets of this account may not be commingled with other property except in a common trust fund or common investment fund.
3. Neither the account owner nor the 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

1. Distributions of funds from this HSA may be made upon the direction of the account owner.
2. Distributions from this HSA that are used exclusively to pay or reimburse qualified medical expenses of the account owner, his or her spouse, or dependents are tax-free. However, distributions that are not used for qualified medical expenses are included in the account owner's gross income and are subject to an additional 20 percent tax on that amount. The additional 20 percent tax does not apply if the distribution is made after the account owner's death, disability, or reaching age 65.
3. The custodian is not required to determine whether the distribution is for the payment or reimbursement of qualified medical expenses. Only the account owner 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 account owner 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 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 death. If the beneficiary is the account owner's estate, the fair market value of the account as of the date of 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.

Article VIII

1. The account owner agrees to provide the custodian with information necessary for the custodian to prepare any report or return required by the IRS.
2. The custodian agrees to prepare and submit any report or return as prescribed by the IRS.

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.

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.

Article XI

Article XI may be used for any additional provisions. If no other provisions will be added, draw a line through this space. If provisions are added, they must comply with the requirements of Article IX.

Account owner's signature _____ Date _____

Custodian's signature For Internal Use Date _____

Witness' signature N/A

(Use only if signature of account owner or custodian is required to be witnessed.)

What's New

Additional Tax Increased. For tax years beginning after December 31, 2010, the additional tax on distributions not used for qualified medical expenses increases from 10% to 20%.

General Instructions

Section references are to the Internal Revenue Code.

Purpose of Form

Form 5305-C is a model custodial account agreement that has been approved by the IRS. An HSA is established after the form is fully executed by both the account owner and the custodian. The form can be completed at any time during the tax year. This account must be created in the United States for the exclusive benefit of the account owner.

Do not file Form 5305-C with the IRS. Instead, keep it with your records. For more information on HSAs, see Notice 2004-2, 2004-2 I.R.B. 269, Notice 2004-50, 2004-33 I.R.B. 196, Pub. 969, Health Savings Accounts and Other Tax-Favored Health Plans, and other IRS published guidance.

Definitions

Identifying Number. The account owner'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. An employer identification number (EIN) is required for an HSA for which a return is filed to report unrelated business taxable income. An EIN is also required for a common fund created for HSAs.

High Deductible Health Plan (HDHP). For calendar year 2011, an HDHP for self-only coverage has a minimum annual deductible of $1,200 and an annual out-of-pocket maximum (deductibles, co-payments and other amounts, but not premiums) of $5,950. In 2012, the $1,200 minimum annual deductible remains the same and the annual out-of-pocket maximum increases to $6,050. For calendar year 2011, an HDHP for family coverage has a minimum annual deductible of $2,400 and an annual out-of-pocket maximum of $11,900. In 2012, the $2,400 minimum annual deductible remains the same and the annual out-of-pocket maximum increases to $12,100. These limits are subject to cost-of-living adjustments after 2012.

Self-only coverage and family coverage under an HDHP. Family coverage means coverage that is not self-only coverage.

Qualified medical expenses. Qualified medical expenses are amounts paid for medical care as defined in section 213(d) for the account owner, his or her spouse, or dependents (as defined in section 152) but only to the extent that such amounts are not compensated for by insurance or otherwise. With certain exceptions, health insurance premiums are not qualified medical expenses.

Custodian. A custodian of an HSA must be a bank, an insurance company, a person previously approved by the IRS to be a custodian of an individual retirement account (IRA) or Archer MSA, or any other person approved by the IRS.

Specific Instructions

Article XI. Article XI and any that follow it may incorporate additional provisions that are agreed to by the account owner and custodian. The additional provisions may include, for example, definitions, restrictions on rollover contributions from HSAs or Archer MSAs (requiring a rollover not later than 60 days after receipt of a distribution and limited to one rollover during a one-year period), investment powers, voting rights, exculpatory provisions, amendment and termination, removal of custodian, custodian's fees, state law requirements, treatment of excess contributions, distribution procedures (including frequency or minimum dollar amount), use of debit, credit, or stored-value cards, return of mistaken distributions, and descriptions of prohibited transactions. Attach additional pages if necessary.

HEALTH SAVINGS ACCOUNT (HSA) DEBIT CARD APPLICATION

BANK OF CASHTON
P.O. BOX 70
CASHTON, WI 54619
PHONE: (800) 205-7203 / FAX: (608) 654-5297

HSA OWNER INFORMATION

FULL NAME (FIRST, M.I., LAST)			HSA ACCOUNT NUMBER
STREET ADDRESS	MAILING ADDRESS (IF DIFFERENT)		SOCIAL SECURITY NUMBER (SSN)
CITY, STATE, ZIP	CITY, STATE, ZIP (IF DIFFERENT)		EMAIL ADDRESS
HOME PHONE NUMBER	WORK PHONE NUMBER	CELL PHONE NUMBER	DATE OF BIRTH

AUTHORIZED SIGNER (OPTIONAL)

FULL NAME (FIRST, M.I., LAST)				
STREET ADDRESS		MAILING ADDRESS (IF DIFFERENT)		
CITY, STATE, ZIP		CITY, STATE, ZIP (IF DIFFERENT)		
SOCIAL SECURITY NUMBER	DATE OF BIRTH	HOME PHONE NUMBER	WORK PHONE NUMBER	CELL PHONE NUMBER

You will receive a PIN Mailer around the time your debit card arrives in the mail. The PIN Mailer will contain your randomly selected PIN (Personal Identification Number) for your card. If you would like to select a PIN number for your Bank of Cashton HSA VISA check card, you can do so by stopping into the Bank of Cashton or calling us at (608) 654-5121 to obtain your "Easy PIN Reference Number".

By using this card, I agree to the terms and conditions of the Bank of Cashton's cardholder agreement provided to me. I understand that the Internal Revenue Service (IRS) limits use of this account to qualified medical expenses and that any non-qualified expenditures must be reported to the IRS.

I have thoroughly read and understand the Bank of Cashton Debit Card rules and related disclosures and will comply with them. By signing below, I accept responsibility for the Card as set forth in the rules/disclosure.

X _____
Signature of HSA Owner **Date**

X _____
Signature of Authorized Signer (Person Designated in Section #5) **Date**

FOR INTERNAL USE ONLY

CARD #	_____		**CARD #**	_____	
Core System	_____	_____	Core System	_____	_____
Card System	_____	_____	Card System	_____	_____

AUTHORIZATION AGREEMENT FOR ACH TRANSFER

BANK OF CASHTON
P.O. BOX 70
CASHTON, WI 54619
PHONE: (800) 205-7203 / FAX: (608) 654-5297

PLEASE NOTE: **This form is NOT for initial contributions.** **Initial contributions must be made by check.** Also, contributions made via ACH Contribution cannot be made for prior year. Prior year contributions (January 1 through April 15) must be made by check. **Do not complete this agreement for ACH Transfer if your HSA contributions will be coming from your employer or through your payroll.**

APPLICANT: _____ HSA Account #: _____

I hereby authorize the Bank of Cashton to initiate debit entries to my account at the financial institution named below to be deposited into the Health Savings Account (HSA). I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I agree to be bound by the terms and conditions found in the Application, Account Agreement, Health Savings Custodial Account, IRS Form 5305-C, HSA Account Disclosures and any amendments thereto.

I request authorization to initiate credit entries (contributions) to my HSA account.

Transfer From Account (debit):

Name of Financial Institution	
Address	
City, State, Zip Code	
Phone Number	
Account Type	
Account Number	
Nine-Digit Routing Number	

Transfer To (credit):
Bank of Cashton
P.O. Box 70
Cashton, WI 54619

I authorize the Bank of Cashton to withdraw $_____ from the account mentioned above and deposit it into my HSA account _____ (Insert frequency of transfer) beginning on _____ (Insert date of when you would like the ACH transfers to begin).

PLEASE NOTE: **This form is NOT for initial contributions.** **Your initial contribution must be made by check.** **Please make this check payable to the Bank of Cashton and it will be deposited into your HSA for your initial contribution.** **If the draw date you have selected falls on a weekend or holiday, your transaction will occur on the next business day.**

X _____

Signature of HSA Owner **Date**

HEALTH SAVINGS ACCOUNT (HSA)
INTERNET BANKING ENROLLMENT FORM

BANK OF CASHTON
P.O. BOX 70
CASHTON, WI 54619
PHONE: (800) 205-7203 / FAX: (608) 654-5297

APPLICANT: _____ HOME PHONE: _____

ADDRESS: _____ WORK PHONE: _____

CITY, STATE, ZIP: _____ CELL PHONE: _____

EMAIL: _____ SSN: _____

MOTHER'S MAIDEN NAME: _____ DOB: _____

Please fill in your Mother's maiden name as we will use this information for additional account security.

By signing below I agree to Bank of Cashton's terms and conditions regarding Internet Banking. Access to my account information is possible only through use of a password. I will not hold Bank of Cashton responsible for activity on my account if my password is compromised. Transfers occurring after 4:00 p.m. will be credited to the next business day.

You will receive a letter in the mail containing your password within one week of the Bank of Cashton receiving this form back from you.

☐ ***Please sign me up to receive the Bank of Cashton monthly newsletter which contains financial tips and additional HSA information. This newsletter will be emailed to the email address above.***

X _____

Signature of HSA Owner **Date**