BANK OF CASHTON

HSA INFORMATION CHECKLIST

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

HEALTH SAVINGS ACCOUNT (HSA) APPLICATION

1. 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**	**GENDER**
				☐ Male ☐ Female
EMPLOYER	**DRIVER'S 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 TIN	DATE OF BIRTH	RELATIONSHIP TO HSA OWNER
%				
%				
%				
TOTAL 100%				

B. CONTINGENT BENEFICIARY

PERCENTAGE	NAME OF BENEFICIARY	SSN OR TIN	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.

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

Signature of Spouse _____ Date _____

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)**		**DRIVER'S 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 Agreement, IRS Form 5305-C, HSA Account Disclosures (available anytime at **www.bankofcashton.bank** 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 finan-cial 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

HSA OWNER SOCIAL SECURITY NUMBER

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. By signing below, I am also agreeing to the terms of the Health Savings Custodial Account Agreement attached hereto, which was adapted from IRS Form 5305-C.

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 Debit Card Application).
- ☐ I would like two FREE Visa® debit cards, one issued in my name and a second issued for the Authorized Signer listed above (See Debit Card Application).
- ☐ 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.

Signature of HSA Owner _____ Date _____

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

Signature of Custodian _____ Date _____

HOW DID YOU HEAR ABOUT THE BANK OF CASHTON?

_____

_____

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.bank** 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.

HEALTH SAVINGS CUSTODIAL ACCOUNT AGREEMENT *(under section 223(a) of the Internal Revenue Code)*

The Account Owner named on the HSA Application (the "Application") 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 HSA 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. The Account Owner has assigned to this Custodial Account the amount indicated in the Application. The Account Owner and the Custodian make the following Agreement:

ARTICLE I. CONTRIBUTIONS

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. CONTRIBUTION LIMITS

1. Contributions to the Account Owner's HSA are subject to a maximum annual limit, based on whether the Account Owner has elected single or family coverage under the HDHP. For calendar year 2025, the maximum annual contribution limit for an Account Owner with single coverage is $4,300 and will be $4,400 in 2026. For calendar year 2025, the maximum annual contribution limit for an Account Owner with family coverage is $8,550 and will be $8,750 in calendar year 2026. Each of these limits are subject to annual cost-of-living adjustments.
2. 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.
3. 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. ACCOUNT OWNER RESPONSIBILITIES

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 and the Account Owner indemnifies and holds the Custodian harmless from any such excess contribution.

ARTICLE IV. NONFORFEITABILITY

The Account Owner's interest in the balance in this Custodial Account is nonforfeitable.

ARTICLE V. INVESTMENT LIMITATIONS

1. No part of the custodial funds in this HSA may be invested in life insurance contracts or in collectibles as defined in section 408(m).
2. The assets of this HSA 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 HSA (such as borrowing or pledging the HSA or engaging in any other prohibited transaction as defined in section 4975).

ARTICLE VI. DISTRIBUTIONS

1. Distributions of funds from this HSA may be made upon the direction of the Account Owner. Account Owner is solely responsible to determine what is a Qualified Medical Expense. Custodian does not verify the distributions for eligibility. In the event Account Owner makes a mistake in a distribution, Account Owner will promptly return such mistaken distribution into the HSA.
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. PAYMENT UPON DEATH

If the Account Owner dies before the entire interest in the HSA is distributed, the entire HSA 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 HSA as of the date of death is taxable on the Account Owner's final return. For other beneficiaries, the fair market value of the HSA is taxable to that person in the tax year that includes such date.

ARTICLE VIII. REPORTING REQUIREMENTS

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. CONTROLLING PROVISIONS

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 article in this Agreement that is inconsistent with section 223 or IRS published guidance will be void.

ARTICLE X. AMENDMENTS

The Custodian may amend this Agreement in any respect at any time (including retroactively), so that it may conform with applicable provisions of the Code, or with any other applicable law as in effect from time to time, or to make such other changes to this Agreement as the Custodian deems advisable. Any such amendment shall be effected by delivery to the Custodian and to the Account Owner at his or her last known address, including an electronic address (as shown in the records of the Custodian) a copy of such amendment or a restatement of this Agreement. The Account Owner shall be deemed to consent to any such amendment(s) if he or she fails to object thereto by sending notice to the Custodian, in a form and manner acceptable to the Custodian, within thirty (30) calendar days from the date a copy of such amendment is delivered to the Account Owner.

ARTICLE XI. DISCLOSURE STATEMENT

This Agreement incorporates by reference Custodian's standard HSA Account Disclosure Statement (the "Disclosure"). A copy of the Disclosure will be made available at Account Owner's request.

ARTICLE XII. FEES AND EXPENSES

Account Owner agrees to pay the fees associated with the HSA. Custodian has the right to modify the fees and will provide notification of modifications in a reasonable manner. Custodian also may charge additional fees upon thirty (30) days prior written notice. Account Owner agrees that Custodian may collect these fees through automatic debiting of the HSA or through another method at the discretion of Custodian. Account Owner agrees that Custodian may deduct any reasonable expenses it incurs in the administration of Account Owner's HSA from Account Owner's HSA. Additionally, Custodian has the right to liquidate Account Owner's HSA assets to pay such fees and expenses. These expenses may include professionals hired by Custodian in connection with Account Owner's HSA.

ARTICLE XIII. ACCOUNT OWNER'S REPRESENTATIONS

Account Owner represents that any information given to Custodian by Account Owner is accurate and complete, including any information contained on the Application. Account Owner understands and represents that Account Owner is responsible for any penalties, taxes, judgments, or expenses Account Owner incurs in connection with this HSA. Account Owner understands that Custodian has no duty to determine Account Owner's eligibility for the HSA or Account Owner's tax consequences for actions taken with respect to the HSA, including, without limitation, deductibility of contributions and the taxability of distributions. Account Owner agrees that Account Owner is solely responsible for determining eligibility for contributions and the tax consequences of contributions and distributions.

ARTICLE XIV. INDEMNIFICATION

Account Owner agrees to indemnify, defend, and hold harmless Custodian from and against any liability arising from (i) actions taken by Custodian in good faith pursuant to this Agreement; (ii) Account Owner's breach of this Agreement; (iii) Account Owner's eligibility; or (iv) distributions directed by Account Owner.

ARTICLE XV. TERMINATION

The Account Owner may terminate the HSA at any time upon notice to the Custodian in a manner and form acceptable to the Custodian. Upon such termination, the Custodian shall transfer the assets of the HSA, reduced by the amount of any unpaid fees or expenses, to the custodian or trustee of another health savings account (within the meaning of Section 223 of the Code) designated by the Account Owner. The Custodian shall not be liable for losses arising from the acts, omissions, delays, or other inaction of any such transferee custodian or trustee.

ARTICLE XVI. MISCELLANEOUS

1. Governing Law. This Agreement shall be construed and interpreted in accordance with the laws of the State of Wisconsin except when in conflict with federal law. Any dispute arising from this Agreement shall be venued in the federal or state courts for Monroe County, Wisconsin.
2. Severability. Should a provision of this Agreement be or become invalid, illegal, or unenforceable, the validity, legality, and enforceability of the remaining provisions shall not in any way be affected or impaired thereby and such provision shall be ineffective only to the extent of such invalidity, illegality, or unenforceability.
3. Definitions:
   a. IRS refers to you as the Depositor, and us as the Custodian. References to "you" and "your" mean the Depositor, and references to "we" mean the Custodian.
   b. Account Owner. Account Owner means the individual named as the HSA owner on the Application for whose benefit the HSA is established.
   c. Agreement. Agreement means the Health Savings Custodial Account (adapted from IRS Form 5305-C), Application, Disclosure Statement, and accompanying documentation.
   d. Application. Application means the legal document that establishes this HSA after acceptance by the Custodian by signing the Application. The information and statements contained in the Application are incorporated into this Agreement.
   e. Beneficiary. Beneficiary means the person(s) or entity(ies) the Account Owner designates in writing in a form and manner acceptable to the Custodian that will be entitled to receive the proceeds in the Custodial Account upon the death of the Account Owner.
   f. Code. Code means the Internal Revenue Code.
   g. Custodial Account. Custodial Account means the type of legal arrangement whereby the Custodian is a qualified financial institution that agrees to maintain the Custodial Account for the exclusive benefit of the Account Owner. For the avoidance of doubt, the HSA created herein is a Custodial Account.
   h. Custodian. The Custodian is Bank of Cashton, a Wisconsin state bank.
   i. High Deductible Health Plan (HDHP). A HDHP means a health plan that satisfies the requirements of Section 233(c)(2) of the Code with respect to deductibles and out-of-pocket expenses. For calendar year 2025, the minimum annual deductible for self-only coverage is $1,650, and the annual out-of-pocket maximum is $8,300. In 2026, the minimum annual deductible for self-only coverage is $1,700, and the annual out-of-pocket maximum is $8,500. For calendar year 2025, the minimum annual deductible for family coverage is $3,300, and the annual out-of-pocket maximum is $16,600. In 2026, the minimum annual deductible for family coverage is $3,400, and the annual out-of-pocket maximum is $17,000.
   j. 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.
   k. 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.
   l. Regulations. Regulations mean the U.S. Treasury Regulations.
   m. Self-Only Coverage and Family Coverage Under an HDHP. Family coverage means coverage that is not self-only coverage.
4. This HSA must be created in the United States for the exclusive benefit of the Account Owner.

HEALTH SAVINGS ACCOUNT DEBIT CARD APPLICATION

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.

Signature of HSA Owner _____ Date _____

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

FOR INTERNAL USE ONLY

CARD # _____ **CARD #** _____

Core System _____ _____ Core System _____ _____

Card System _____ _____ Card System _____ _____

SINCE 1899

P.O. Box 70, Cashton, Wisconsin 54619 **PHONE** (800) 205-7203 **FAX** (608) 654-5297 **WEB** BankofCashton.Bank

AUTHORIZATION AGREEMENT FOR ACH TRANSFER

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 Agreement, 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 prior business day.**

_____ _____
Signature of HSA Owner Date

HEALTH SAVINGS ACCOUNT (HSA) INTERNET BANKING AND MOBILE BANKING APP ENROLLMENT FORM

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.

_____

Signature of HSA Owner Date