HEALTH SAVINGS ACCOUNTS

Providing Health Savings Account services for well over a decade. We are one of the largest credit union providers in the state of Ohio!

Pathways
Financial Credit Union

Your path to better banking.

ABOUT PATHWAYS

Pathways is a not-for-profit, full-service financial institution dedicated to maximizing savings for our member-owners. When you bank with us you own a share of our credit union; as the most important piece of our organization we put your needs first in every decision we make, product we develop, and service we offer.

ABOUT HEALTH SAVINGS ACCOUNTS

Our Health Savings Account program serves as a valuable resource along your path to good health. Health Savings Accounts (HSAs) are designed for those covered by a High-Deductible Health Plan (HDHP) to pay for qualified medical expenses using a pre-tax savings account. You can use a debit card to pay for medical expenses such as doctor visits, prescriptions, eye care, dental care, and more. Funds in the HSA can be rolled over each year, continuing to earn tax-free dividends.

Pathways' Health Savings Account program has NO monthly or annual fees for e-statement members!

HSA BENEFITS:

- Realize significant savings on medical bills since HSA contributions are tax free
- Cover most medical, dental and prescription costs
- There are no "use it or lose it" with HSAs - your funds can build from year-to-year
- Account is transferrable in the event of a job change

BENEFITS OF THE PATHWAYS HEALTH SAVINGS ACCOUNT:

- Pay no monthly or annual fees on your Pathways Health Savings Account when you have e-statements
- Dividends among the most competitive you'll find
- FREE Pathways HSA debit card to pay for qualified medical
- expenses
- Options available to pay medical bills and expenses with HSA checks or cash from your account
- Rollover and transfer service included
- FREE account access through our mobile app, online banking and text banking
- Access your HSA at any branch of Pathways Financial Credit Union plus thousands of Shared Branching locations across the United States and foreign countries
- Investment options available

HOW TO OPEN YOUR HSA

We make it easy to open your HSA at Pathways Financial Credit Union with two simple and convenient options.

OPTION 1 - OPEN ONLINE

The quickest and easiest way to open and/or transfer your HSA is to go to the HSA section of our website and then follow the simple directions for opening online. Visit the Health Savings Account section on our website at ***pathwayscu.com.***

OPTION 2 - USE PAPER APPLICATION

If you do not want to open your HSA online, you can complete and return the enclosed applications. Just follow the steps below and then mail your completed application, along with a photo copy of your Driver's License, to Pathways. Here are your 3 easy steps.

STEP #1

Page 3 - Complete your membership application

STEP #2

Page 4 & 5 - Complete the application sections of your HSA Account Simplifier

STEP #3

Page 6 - Complete this form only if you are transferring an existing HSA from another institution to Pathways.
Make sure you have signed and dated all the appropriate forms and made a photo copy of your Driver's License (or government issued ID). Then mail your application and the copy of your Driver's License to:

Pathways Financial CU
Attn: HSA Dept.
5665 N. Hamilton Rd.
Columbus, OH 43230

For a list of all Pathways branches, or to find a Pathways location nearest to you, please visit ***pathwayscu.com/locations***

OFFICE HOURS

Monday-Thursday	8:30 a.m. - 5:00 p.m.
Friday	8:30 a.m. - 6:00 p.m.
Saturday	9:00 a.m. - Noon (Columbus West & Marysville Only)

DRIVE-THRU HOURS

Monday-Thursday	8:30 a.m. - 5:00 p.m.
Friday	8:30 a.m. - 6:00 p.m.
Saturday	9:00 a.m. - Noon (Columbus West & Marysville Only)

pathwayscu.com • mail@pathwayscu.com

Membership Application

Applicant Information

☐ I am a member ☐ I want to join

Name SSN Birth Date

Mother's Maiden Name Street Address

City State Zip How long?

Home Phone/Cell Work Phone Email

Membership Eligibility

Live/Work/Worship in: Employer:

Driver's License # State Issued Issue Date Expiration Date

Would you like to add Beneficiaries?

☐ Yes ☐ No

1)Name SSN Birth Date

Street Address % assignment:

City State Zip Contact #

2)Name SSN Birth Date

Street Address % assignment

City State Zip Contact #

Is this an individual employee or family health plan? ☐ Individual Employee ☐ Family Plan

If Family Plan, would you like an extra HSA Debit Card? ☐ Yes ☐ No

Name SSN Birth Date

☐ Check here if you need checks for your HSA account.

TIN Certification and Backup Withholding Information

By signing below, I certify, in accordance with the IRS W-9 instructions provided by the Credit Union and under penalties of perjury that the Social Security Number (SSN)/Taxpayer Identification Number (TIN) shown is my correct identification number and that I am NOT, unless designated below, subject to backup withholdings becasue I have not been notified that I am subject to backup withholdings as a result of a failure to report all dividends and interest, or becase the IRS has notified me that I am no longer subject to backup withholding, an I am a U.S. person (including a U.S. resident alien).

☐ I am subject to backup withholding ☐ Exempt ☐ I am not a U.S. citizen or resident (Complete W-8 form)

This application is submitted to attain credit. I (We) certify that all information herin is true and complete. I (We) authorize the Credit Union to verify or obtain further information the Credit Union may deem necessary concerning my (our) credit standing. By signing the application, I (We) agree to the terms and disclosures that are included as well as any additional disclosures that are sent to me (us) by the credit union.

Customer Identification Program

Will the use of this Account be for anything other than for household, family, or persoal purposes? ☐ Yes ☐ No

Do you intend to conduct recurring wire transfer activity or have regular large cash deposits and/or withdrawals on this Account? ☐ Yes ☐ No

Do you intend to use your Account for proceeds from marijuana business activity? ☐ Yes ☐ No

Have you, or anyone you are related to, ever held a political office outside the United States? ☐ Yes ☐ No

IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING A NEW ACCOUNT WITH PATHWAYS FINANCIAL CREDIT UNION:

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 ask to see your driver's license or other identifying documents.

By signing this form you accept all the terms and conditions contained in the membership agreement and addendums.

X_____

Applicant Signature **Date**

HSA Simplifier®

HEALTH SAVINGS ACCOUNT APPLICATION

PART 1. HSA OWNER

Name *(First/MI/Last)* _____

Address Line 1 _____

Address Line 2 _____

City/State/ZIP _____

Social Security Number _____

Date of Birth _____ Phone _____

Email Address _____

Account Number _____

PART 2. HSA CUSTODIAN

To be completed by the HSA custodian

Name _____

Address Line 1 _____

Address Line 2 _____

City/State/ZIP _____

Phone _____ Organization Number _____

☐ *This is an amendment to an existing HSA.*

PART 3. CONTRIBUTION INFORMATION

Contribution Amount _____ Contribution Date _____

CONTRIBUTION TYPE *(Select one)*

☐ **1. Regular** *(Includes catch-up contributions as well as qualified HSA funding distributions from an IRA)*
Contribution for Tax Year _____ *(Qualified HSA funding distributions from an IRA must be made for the current tax year)*

☐ **2. Rollover** *(Distribution from an HSA or Archer MSA that is being deposited into this HSA)*
By selecting this transaction, I irrevocably designate this contribution as a rollover.

☐ **3. Transfer** *(Direct movement of assets from an HSA or Archer MSA into this HSA)*

PART 4. INVESTMENT AND DEPOSIT INFORMATION

INVESTMENT INFORMATION *(Complete this section as applicable.)*

Investment Description	Quantity or Amount	Investment Number	Term or Maturity Date	Interest Rate

DEPOSIT METHOD

☐ **Cash or Check** *(If the contribution type is transfer, the check must be from a financial organization made payable to the custodian for this HSA.)*

☐ **Internal Account**
Account Number _____ Type *(e.g., checking, savings, HSA)* _____

☐ **External Account** *(e.g., EFT, ACH, wire) (Additional documentation may be required and fees may apply.)*
Name of Organization Sending the Assets _____ Routing Number *(Optional)* _____
Account Number _____ Type *(e.g., checking, savings, HSA)* _____

Deposit Taken by _____

3500 / 2600H-C (Rev. 10/2018)

Name of HSA Owner _____, Account Number _____

PART 5. BENEFICIARY DESIGNATION

I designate that upon my death, the assets in this account be paid to the beneficiaries named below. The interest of any beneficiary that predeceases me terminates completely, and the percentage share of any remaining beneficiaries will be increased on a pro rata basis. If no beneficiaries are named, my estate will be my beneficiary.

☐ I elect not to designate beneficiaries at this time and understand that I may designate beneficiaries at a later date.

PRIMARY BENEFICIARIES *(The total percentage designated must equal 100%. If more than one beneficiary is designated and no percentages are indicated, the beneficiaries will be deemed to own equal share percentages in the HSA.)*

Name_____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID *(SSN/TIN)* _____ Percent Designated_____

Name_____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID *(SSN/TIN)* _____ Percent Designated_____

Name_____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID *(SSN/TIN)* _____ Percent Designated_____

Name_____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID *(SSN/TIN)* _____ Percent Designated_____

CONTINGENT BENEFICIARIES *(The total percentage designated must equal 100%. If more than one beneficiary is designated and no percentages are indicated, the beneficiaries will be deemed to own equal share percentages in the HSA. The balance in the account will be payable to these beneficiaries if all primary beneficiaries have predeceased the HSA owner.)*

Name_____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID *(SSN/TIN)* _____ Percent Designated_____

Name_____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID *(SSN/TIN)* _____ Percent Designated_____

Name_____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID *(SSN/TIN)* _____ Percent Designated_____

Name_____
Address _____
City/State/ZIP _____
Date of Birth _____ Relationship _____
Tax ID *(SSN/TIN)* _____ Percent Designated_____

☐ *Check here if additional beneficiaries are listed on an attached addendum.* Total number of addendums attached to this HSA _____

PART 6. SPOUSAL CONSENT

Spousal consent should be considered if either the trust or the residence of the HSA owner is located in a community or marital property state.

CURRENT MARITAL STATUS

☐ **I Am Not Married –** I understand that if I become married in the future, I should review the requirements for spousal consent.

☐ **I Am Married –** I understand that if I choose to designate a primary beneficiary other than or in addition to my spouse, my spouse should sign below.

CONSENT OF SPOUSE

I am the spouse of the above-named HSA owner. I acknowledge that I have received a fair and reasonable disclosure of my spouse's property and financial obligations. Because of the important tax consequences of giving up my interest in this HSA, I have been advised to see a tax professional.

I hereby relinquish any interest that I may have in this HSA and consent to the beneficiary designation indicated above. I assume full responsibility for any adverse consequences that may result.

X _____ _____
Signature of Spouse — Date *(mm/dd/yyyy)*

X _____ _____
Signature of Witness — Date *(mm/dd/yyyy)*

PART 7. SIGNATURES

Important: *Please read before signing.*
I understand the eligibility requirements for the type of HSA contribution I am making, and I state that I do qualify to make the contribution. I have received a copy of the Health Savings Account Application, the 5305-C Custodial Account Agreement, and the Disclosure Statement. I understand that the terms and conditions that apply to this HSA are contained in this Application and the HSA Custodial Account Agreement. I agree to be bound by those terms and conditions.

I assume complete responsibility for

- determining that I am eligible for an HSA each year I make a contribution,
- ensuring that all contributions I make are within the limits set forth by the tax laws, and
- the tax consequences of any contributions (including rollover contributions) and distributions.

X _____ _____
Signature of HSA Owner — Date *(mm/dd/yyyy)*

X _____ _____
Signature of Witness — Date *(mm/dd/yyyy)*

X _____ _____
Signature of Custodian — Date *(mm/dd/yyyy)*

HSA TRANSFER REQUEST

PART 1. RECIPIENT

Individual requesting the transfer

Name *(First/MI/Last)* _____

Date of Birth_____ Phone _____

Email Address _____

Account Number_____ Suffix _____

RELATIONSHIP TO CURRENT OWNER *(Select one)*

☐ I am the current account owner.

☐ I am the former spouse of the current account owner.

PART 2. ACCEPTING HSA TRUSTEE OR CUSTODIAN

To be completed by the HSA trustee or custodian receiving the assets

Name_____

Address Line 1_____

Address Line 2_____

City/State/ZIP _____

Phone_____ Organization Number _____

Contact Name_____

PART 3. CURRENT ACCOUNT OWNER

Name *(First/MI/Last)* _____

Social Security Number _____

Account Number_____ Suffix _____

CURRENT ACCOUNT TYPE *(Select one)* ☐ HSA ☐ Archer MSA

PART 4. CURRENT ACCOUNT TRUSTEE OR CUSTODIAN

Name_____

Address Line 1_____

Address Line 2_____

City/State/ZIP _____

Phone _____

PART 5. TRANSFER INSTRUCTIONS

TRANSFER OPTIONS *(Select one)*

☐ **One-Time Transfer**

Transfer Amount _____ Transfer Date _____

☐ Entire Account Balance ☐ This Transfer Will Close the Current Account

☐ **Recurring Transfer**

Transfer Amount _____ Transfer Start Date _____

Frequency *(Select one)* ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually ☐ Other _____

MAKE PAYABLE TO

_____ as ☐ Trustee or ☐ Custodian of _____ HSA

Name of Accepting HSA Trustee or Custodian — Name of Recipient

ASSET HANDLING *(Investments identified below will be liquidated immediately unless otherwise specified in the Special Instructions section.)*

Asset Description	Amount to be Transferred	Special Instructions

PART 6. SIGNATURES

I authorize the transfer of these assets and certify that all information provided by me is true and accurate. I understand that I am responsible for determining that this transfer qualifies under the rules that apply to such transfers and agree to comply with those rules. I assume responsibility for any consequences that may result from this transfer and I agree that the trustee or custodian is not responsible for any consequences that may arise from executing this transfer request.

The trustee or custodian signing below agrees to accept the assets being transferred.

X _____ _____

Signature of Recipient — Date *(mm/dd/yyyy)*

X _____ _____

Notary Public/Signature Guarantee *(If required by the trustee or custodian)* — Date *(mm/dd/yyyy)*

X _____ _____

Authorized Signature of Accepting Trustee or Custodian — Date *(mm/dd/yyyy)*