



## **Application Instructions**

1. Print and fill out entire PerfectHealth Savings Account (PHSA) Application.
2. Write a \$20.00 check payable to New York Community Bank for your PHSA set up fee.
3. Mail application and check to:

New York Community Bank  
Banking Services - H.S.A. Processing  
NYCB Plaza  
102 Duffy Avenue  
Hicksville, NY 11801

To speak to a representative, call 1-800-552-4395

# PerfectHealth Savings Account Application and Eligibility Form

**Personal Information:**

Social Security Number: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Years at the Current Address: \_\_\_\_\_ *(If less than 2 years, please complete the prior address information below)*  
 Prior Street Address: \_\_\_\_\_  
 Prior City: \_\_\_\_\_ Prior State: \_\_\_\_\_ Prior Zip: \_\_\_\_\_  
 Home Phone Number: \_\_\_\_\_ Business Phone Number: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_

**Employer Information**

Employment Status:  Employed  Unemployed  Retired  
 Employer's Name: \_\_\_\_\_ Federal ID # \_\_\_\_\_  
 Employer's Street Address: \_\_\_\_\_  
 Employer's City: \_\_\_\_\_ Employer's State: \_\_\_\_\_ Employer's Zip: \_\_\_\_\_  
 Length of Employment: Years \_\_\_\_\_ Months \_\_\_\_\_ Position or Title: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_

**Citizenship Information**

Are you a U.S. Citizen?:  Yes  No *(If no, please complete the information below)*  
 Country of Citizenship: \_\_\_\_\_  
 Passport Number: \_\_\_\_\_ Country of Issuance: \_\_\_\_\_  
 I am a:  Permanent Resident  Resident Alien  Non-Resident Alien  Non-Immigrant

**For Security Purposes** *(Your answers to the questions below will be used for identity verification purposes)*

1. What is your mother's maiden name? \_\_\_\_\_
2. What is your mother's date of birth (not including year)? \_\_\_\_\_
3. Primary School or High School you attended: \_\_\_\_\_
4. What is the street you grew up on? \_\_\_\_\_

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## Primary Identification (Required)

- Driver's License (If you do not possess a driver's license, please select one of the following)
- Student Visa (I20 Number: \_\_\_\_\_)       State Issued non-driver's I.D.     U.S. Passport
- Government identification card with photo       Alien Registration Card       Foreign Passport

Source of Issuance: \_\_\_\_\_ Identification Number: \_\_\_\_\_

Issuance Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Is the Address on the Identification Current?:  Yes     No     N/A

(If no, please complete the address information below with the information shown on the identification)

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Contribution Information

### General Contribution Information

Amount \$ \_\_\_\_\_

Contribution Date \_\_\_\_\_

Tax Year \_\_\_\_\_

### Contribution Type

- Regular       Transfer from a Health Savings Account
- Rollover from a Health Savings Account       Catch-Up (age 55 or older and not enrolled in Medicare)
- Rollover from an Archer Medical Savings Account       Transfer from an Archer Medical Savings Account

## Contributor Information

Contributor Relationship to Health Savings Account (HSA) Owner (select one):

- HSA Owner     Employer     Family Member     Other \_\_\_\_\_

## HSA Account Options:

Please select the additional services you would like for your HSA (check all that apply):

- I would like to receive an order of 120 FREE checks to use with my HSA Account
- I would like to receive a FREE VISA® check card issued in my name for my HSA Account.

When you receive your welcome packet including your account number and would like to enroll in the Bank's FREE Online Banking with Bill Payment Service go to **mynycb.com** and apply.

*Purchases made with the VISA® check card, New York Community Bank checks, or New York Community Bank's Online Banking Bill Payment Service will be reported by the Bank as "qualified current-year distributions" and should only be used for qualified medical expenses. All Contributions or Transfers made through the New York Community Bank Online System into your Health Savings Account will be reported as **Current Year Contributions** on year end reporting documents.*

**\*\*Please read the Authorized Signer section for spousal or third party access to your HSA.\*\***

# PerfectHealth Savings Account Application and Eligibility Form

## 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.

### **Primary Beneficiary**

Percentage	Name of Beneficiary	SSN or Taxpayer ID	Date of Birth	Relationship to HSA Owner
_____ %	_____	_____	_____	_____
_____ %	_____	_____	_____	_____
_____ %	_____	_____	_____	_____
Total 100%				

### **Contingent Beneficiary**

Percentage	Name of Beneficiary	SSN or Taxpayer ID	Date of Birth	Relationship to HSA Owner
_____ %	_____	_____	_____	_____
_____ %	_____	_____	_____	_____
_____ %	_____	_____	_____	_____
Total 100%				

## Spousal Consent (Required for Residents of AZ, CA, ID, LA, NV, NM, TX, WA, & WI)

\_\_\_\_\_ **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.  
(HSA Owner Initials)

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 tax or legal 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 Designation of Beneficiary section as set forth above.

\_\_\_\_\_  
Signature of Spouse

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness (if required)

\_\_\_\_\_  
Date

### FOR BANK USE ONLY

Received By: \_\_\_\_\_ Date: \_\_\_\_\_

Processed By: \_\_\_\_\_ Date: \_\_\_\_\_

Account Number: \_\_\_\_\_

Approved By: \_\_\_\_\_ Date: \_\_\_\_\_

Verified By: \_\_\_\_\_ Date: \_\_\_\_\_



102 Duffy Ave - Hicksville, NY 11801

# PerfectHealth Savings Account Application and Eligibility Form

**Eligibility Requirements:**

**Account Holder Certification:** I certify that: (1) I am or effective \_\_\_\_/\_\_\_\_/\_\_\_\_ \* will be covered by a  single or  family qualified High Deductible Health Plan (HDHP), with a deductible of \$\_\_\_\_; (2) I certify that I am not covered by a health plan, other than a HDHP, which provides any of the same benefits as the HDHP; (3) I am not enrolled in Medicare; and (4) I may not be claimed as a dependent on another person's tax return.

Your HSA account will be considered established for tax purposes as of your first date of eligibility under your HDHP, provided that you have signed and dated the application for your HSA on or before that date. If we receive the application after your first date of eligibility under your HDHP, your HSA account will be considered established as of the date you signed and dated this application. To receive tax favored treatment for distributions from your HSA account, any qualified medical expenses must be incurred after the date that your HSA account is established.

*\*Note: Your application will not be processed until the effective date above. Signatures Required Below.*

**Authorized Signer (Optional):** *(Authorized Signer signature required below)*

Regulations require that only one individual own a Health Savings Account. As such, the accountholder may want his/her spouse and/or another third party to act as an authorized signer to write checks or access the account using a VISA® check card.

I (accountholder) hereby designate the following individual as additional authorized signer on my Health Savings Account. As such, any checks that are issued for the account will include the name listed below to facilitate his/her access to my HSA account.

I understand that this designation is an accommodation to me at my request and will not proceed or otherwise bring an action against or make a claim against New York Community Bank, its affiliates and successors in interest (collectively the "Bank"), for any actions by the Bank taken in connection with this designation, including negligence and including payment on an item after designation of the below individual has been revoked by me but before the Bank has had a reasonable time to act. This does not preclude me from seeking compensatory damages in the event of gross negligence by the Bank. I also expressly waive any right I may have for consequential, punitive or exemplary damages.

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Birth Date: \_\_\_\_\_

I would like an additional FREE VISA® check card issued in the name of the Authorized Signer above to be used for normal distributions from my HSA Account.

**Signatures** Important: Please read before signing

I understand the eligibility requirements for the type of HSA deposit I am making. I state that I am or effective the date above qualified to make the deposit. New York Community Bank is hereby appointed to serve as custodian of my HSA account.

**I assume complete responsibility for:**

(1) Determining that I am eligible for an HSA each year I make a contribution. (2) Ensuring that all contributions I make are within the limits set forth by the tax laws. (3) The tax consequences of any contribution (including rollover contributions) and distributions.  
 NOTE: In order to validate your identity as required by Federal Law, we will use information from Consumer Reporting Agencies along with the information you have provided on your application to approve your request for a new HSA account. At the discretion of the Bank we may also validate this information with Credit Reporting Agencies. By completing and submitting this application you authorize the Bank to verify your identification information with these agencies. Additionally you are certifying that the information you are providing is true and accurate. The opening of a new account is contingent upon our ability to adequately verify your identity. You are further more acknowledging that your agreement to have New York Community Bank send you the account terms and conditions, Personal Deposit Account Agreements and Disclosure booklet, schedule of fees, current rate sheet and privacy notice via mail within 10 business days of account opening.

\_\_\_\_\_  
 Account Holder Signature Date

\_\_\_\_\_  
 Signature of Witness Date  
*(Can be anyone other than a family member or the POA who has Witnessed the signing of this form)*

\_\_\_\_\_  
 Authorized Signer (if designated) Date

Printed Name of Witness: \_\_\_\_\_

# PerfectHealth Savings Account Application and Eligibility Form

## HEALTH SAVINGS ACCOUNT CUSTODIAL AGREEMENT

The account holder whose name appears on the attached Application (“Depositor”) is establishing at New York Community Bank a Health Savings Account (“HSA”) under Section 223(a) of the Internal Revenue Code (“Code”) exclusively for the purpose of paying or reimbursing qualified medical expenses of the Depositor and his or her spouse and dependents. The Depositor has assigned to the custodial account the sum indicated on the Application. The Depositor 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 (or as of the effective date as Set forth in the Application will be) 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 preventative 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 Depositor, by submitting the signed Application, and the Custodian, by acceptance of the application and delivery of account items to the Depositor for the Depositor’s HSA, make the following agreement:

**ARTICLE I:** The Custodian may accept additional cash contributions for the tax year made by or on behalf of the Depositor (by an employer, family member or any other person). No contributions will be accepted by the Custodian for the Depositor that exceeds the maximum amount for family coverage plus the catch-up contribution. Contributions for any tax year may be made at any time before the deadline for filing the Depositor’s federal income tax return for that year (without extensions). Rollover contributions from an HSA or an Archer Medical Savings Account (Archer MSA) may not be in cash and must be in the form of a trustee-to-trustee rollover and are not subject to the maximum annual contribution limit set forth in Article II. Rollover contributions from an individual retirement account may not be in cash and must be in the form of a trustee-to-trustee rollover and are not subject to the maximum annual contribution limit set forth in Article II. We also reserve the right not to accept any transfer.

**ARTICLE II:** For calendar year 2019, the maximum annual contribution limit for a Depositor with single coverage is \$3,500.00. The maximum out-of-pocket- expenses for calendar year 2019 for single plan coverage is \$6,750.00. For calendar year 2019, the maximum annual contribution limit for a Depositor with family coverage is \$7,000.00. The maximum out-of-pocket expenses for calendar year 2019 for family plan coverage is \$13,500.00. Eligibility and contribution limits are determined on a month-to-month basis. Contributions to Archer MSAs or other FSAs count toward the maximum annual contribution limit to this HSA. For calendar year 2019, an additional \$1000 catch-up contribution may be made for a Depositor who is at least age 55 or older and not enrolled in Medicare. Contributions in excess of the maximum annual contribution limit (other than catch-up or rollover contributions) are subject to an excise tax. This tax will apply each year in which an excess remains in your HSA.

**ARTICLE III:** The Depositor shall have the sole responsibility 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 Depositor shall notify the Custodian that there exist excess contributions to the HSA. It is the responsibility of the Depositor to request the withdrawal of the excess contribution and any net income attributable to such excess contribution.

**ARTICLE IV:** The Depositor’s interest in this custodial account is non-forfeitable.

**ARTICLE V:** No part of the custodial funds may be invested in life insurance contracts or in collectibles as defined in Code Section 408(m). The assets of this account may not be commingled with other property except in a common trust fund or common investment fund. Neither the Depositor 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 Code Section 4975).

**ARTICLE VI:** Distributions of funds from this HSA may be made upon the direction of the Depositor; withdrawals by the Depositor may be made at a branch, or by use of a Visa® check card, or by checks issued to the Depositor. Distributions from this HSA that are used exclusively to pay or reimburse qualified medical expenses of the Depositor, his or her spouse, or dependents are tax-free. However, distributions that are not used for qualified medical expenses are included in the Depositor’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 Depositor’s death, disability, or reaching age 65. The Custodian is not required to determine whether the distribution is for the payment or reimbursement of qualified medical expenses, only the Depositor 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; any taxes, interest or penalties incurred for Depositor’s violation of this responsibility shall be the sole obligation of the Depositor. Any withdrawals shall be subject to all applicable tax and other laws and regulations including possible early withdrawal penalties and withholding requirements.



# PerfectHealth Savings Account Application and Eligibility Form

**ARTICLE VII:** If the Depositor dies before the entire interest in the account is distributed, the entire account will be disposed of as follows, as designated on the application:

1. If the beneficiary is the Depositor's spouse, the HSA will become the spouse's HSA as of the date of death.
2. If the beneficiary is not the Depositor's spouse, the HSA shall cease to be an HSA account as of the date of death. If the beneficiary is the Depositor's estate, the fair market value of the account as of the date of death is taxable on the Depositor'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:** The Depositor agrees to provide the Custodian with information necessary for the Custodian to prepare any report or return required by the law. The Custodian agrees to submit any report or return as prescribed by the law.

**ARTICLE IX:** You represent and warrant to us that any information you have given or will give us with respect to this Agreement is complete and accurate. Further, you agree that any directions you give us, or action you take will be proper under this Agreement and that we are entitled to rely upon any such information or directions. We shall not be responsible for losses of any kind that may result from your directions to us or your actions or failures to act and you agree to reimburse us for any losses we may incur as a result of such directions, actions, or failures to act. We shall not be responsible for any penalties, taxes, judgments or expenses you incur in connection with your H.S.A. We have no duty to determine whether your contributions or distributions comply with the Code, regulations, rulings or this Agreement.

**ARTICLE X:** Notwithstanding any other article that may be added or incorporated in this agreement, the provisions of Articles I through IX and this sentence are controlling. Any additional article in this agreement that is inconsistent with Code Section 223 or IRS published guidance or law will be void.

**ARTICLE XI:** This Agreement will be amended from time to time to comply with the provisions of the Code or IRS published guidance; these amendments do not require your consent. Other amendments may be made with the consent of the Depositor and the Custodian. You will be deemed to have consented to any other amendment unless, within 30 days from the date we mail the amendment, you notify us in writing that you do not consent.

**ARTICLE XII:** We have the right to charge an annual or monthly service fee or other designated fees (for example, a transfer, withdrawal or termination fee) for maintaining your H.S.A. in accordance with the Schedule of Fees. In addition we have the right to be reimbursed for all reasonable expenses we incur in connection with the administration of your H.S.A. We may charge you separately for any fees or expenses or we may deduct the amount of the fees or expenses from the assets in your H.S.A. at our discretion. We reserve the right to charge any additional fee upon 30 days notice to you that the fee will be effective.

**ARTICLE XIII:** This agreement is subject to all applicable Federal and State laws and regulations. If it is necessary to apply any State law to interpret and administer this Agreement, the law of the State of New York shall govern.

**If any part of this Agreement is held to be illegal or invalid, the remaining parts shall not be affected. Neither your nor our failure to enforce at any time or for any period of time any of the provisions of this Agreement shall be construed as a waiver of such provisions, or your right or our right thereafter to enforce each and every such provision.**

## ARTICLE XIV

*1. Definitions:* In this part of the Agreement (Article XI), the words "I", "you" and "your" refer to the Depositor. The Depositor is the person who establishes the custodial account. The words "we," "our," and "us" refer to the Custodian, New York Community Bank.

*2. Termination:* Either party may terminate the Agreement at any time by giving written notice to the other. We can resign as Custodian at any time effective 30 days after we mail written notice of our resignation to you. Upon receipt of that notice you must make arrangements to transfer your H.S.A. to another financial entity. If you do not complete a transfer of your H.S.A. within 30 days from the date we mail the notice to you, we have the right to transfer your H.S.A. assets to a successor H.S.A. custodian or trustee that we choose at our sole discretion or we may pay your H.S.A. to you in a single sum. We shall not be liable for any actions or failures to act on the part of any successor custodian or trustee nor for any tax consequences you may incur that result from the transfer or distribution of your assets pursuant to this Section.



*A Product of New York Community Bank • Member FDIC*

102 Duffy Ave - Hicksville, NY 11801

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If the Agreement is terminated, we may hold back from your H.S.A. a reasonable amount of money that we believe is necessary to cover any one or more of the following:

- Any fees, expenses, or taxes chargeable against your H.S.A.
- Any penalties associated with the early withdrawal of any savings instrument or other investment in your H.S.A.
- If we merge with, purchase, or are acquired by another organization, or if we transfer the account to an affiliate organization, such organization, if qualified, shall automatically become the successor custodian or trustee of your H.S.A.