

**The Washwick Agency, Inc.**

Administrators for the

**Peconic Bay Business Assoc.**

860 E. Main St.

Riverhead, NY 11901

Phone: 631-369-0888

Fax: 631-369-4438

Dear Prospective Member:

Oxford Health Plans appreciates your business and the opportunity to provide your health benefits. We have enclosed information about enrolling for coverage under Oxford's Sole Proprietor Program. The enrollment process is outlined below.

**Required documentation for New York Sole Proprietor Business**

Oxford Health Plan's underwriting process requires that sole proprietors verify their status by submitting current tax documents. We will not be able to process sole proprietor applications without the following information:

\_\_\_ Sole Proprietor Application form

\_\_\_ If choosing a HSA, make check payable to "Exante Bank"

\_\_\_ A check payable to "PBBA" for annual dues in the amount of \$35

\_\_\_ A check payable to "Oxford Health Plans"

\_\_\_ Member Enrollment Form and Exante Bank Enrollment Form

\_\_\_ Tax Form 1040 (current)

\_\_\_ At least **one** of the following:

- Schedule C – Profit & Loss from Business (Sole Proprietorship)
- Schedule E – Rents & Royalties
- Schedule F – Profit & Loss from Farming  
(Please note: Combined Gross Income on Schedules C, E, and F must total at least \$25,000)
- 1120S and K-1  
(Please note: Oxford will NOT accept 1120 as proof of business)

Please send the forms to:

Peconic Bay Business Assoc.  
Attn: Rosemarie  
860 East Main Street  
Riverhead, NY 11901

If you have any questions, please call us at (631) 369-0888.

**\*\* All applications MUST be in this office by the 13<sup>th</sup> of the month prior to the effective date. \*\***



**PBBA Peconic Bay Business Association  
Membership Application**

- 1) Name of Business \_\_\_\_\_  
Nature of Business \_\_\_\_\_
- 2) Name of Contact Person \_\_\_\_\_
- 3) Address \_\_\_\_\_  
\_\_\_\_\_
- 4) Phone # \_\_\_\_\_
- 5) Fax # \_\_\_\_\_
- 6) Email Address \_\_\_\_\_
- 7) Are You Applying for Medical Benefits? YES ( ) NO ( )

*PLEASE CIRCLE YOUR DESIRED PLAN*

Oxford HSA    #1 Direct Liberty    #2 Metro Liberty    #3 Direct Freedom    #4 Exclusive Freedom

- 8) Name of Insured \_\_\_\_\_
- 9) Insured's Social Security No. \_\_\_\_\_
- 10) Date of Birth \_\_\_\_\_

*I the undersigned would like to apply for membership in the Peconic Bay Business Association. Enclosed is my check for the dues, payable to: "PBBA", in the amount of \$35.*

**Signature of Member** **X** \_\_\_\_\_ **Date** \_\_\_\_\_

**Print Name** \_\_\_\_\_

Administered by: The Washwick Agency, Inc. 860 East Main Street, Riverhead, NY 11901  
Telephone: 631-369-0888                      Fax: 631-369-0618



A UnitedHealthcare Company

## Sole Proprietor and Group of One Attestation Form

### I. Business Organization Information:

- a. Name of Organization: \_\_\_\_\_  
Tax ID # or SS #: \_\_\_\_\_  
Primary Business Activity: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
- b. Contact Information for Business Organization  
Name: \_\_\_\_\_ Fax: \_\_\_\_\_  
Title: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### II. Sole Proprietor Attestation:

By executing this document, I hereby attest that: (i) the above described business organization is not an association, group purchasing organization or employee leasing organization and was formed for a lawful business purpose and not for the primary purpose of obtaining group insurance; (ii) I am the owner and operator of the above described business organization; (iii) I work a minimum of twenty (20) hours per week for this business organization; I derive the majority of my earned income (non-passive or non-investment) from the income generated from the above business organization; (iv) I seek health coverage only for myself and my eligible dependents through the above described business; (v) I (and my eligible dependents) am the only person eligible for health coverage through the above described business organization; (vi) I will promptly advise Oxford in the event that any of the statements made in this Attestation are no longer accurate.

### III. S-Corporations with "One Eligible Employee" Attestation:

By executing this document, I hereby attest that: (i) the above described business organization is not an association, group purchasing organization or employee leasing organization and was formed for a lawful purpose and not for the primary purpose of obtaining group insurance; (ii) I am the sole shareholder of the above described business organization; (iii) I am currently employed by the above described business organization and work a minimum of twenty (20) hours per week for the business organization; (iv) I derive the majority of my earned income (non-passive or non-investment) from services provided to the above business organization; (v) I seek health coverage only for myself and my eligible dependents as listed on my enrollment form; (vi) I (and my eligible dependents) am the only person eligible for health coverage through the above described business organization; and (vi) I will promptly advise Oxford in the event that any of the statements made in this Attestation form are no longer accurate.

### IV. Tax Forms and other Documents (applicable to both Sole Proprietors and S-Corporations):

By executing below, I agree to provide upon request appropriate tax forms to Oxford to validate the eligibility status. Before application will be considered, the applicant must execute this Attestation Form and provide the tax information and related documents indicated on the attached correspondence. Oxford reserves the right to modify these documentation and eligibility requirements in the future.



# NY Sole Proprietor Application

Oxford Health Insurance Inc. ▪ [www.oxfordhealth.com](http://www.oxfordhealth.com)

**Mailing Address:** 14 Central Park Drive, Hooksett, NH 03106 **Attn:** Group Enrollment Department

## I. GENERAL INFORMATION

1. **Full Legal Name of Group:**

2. **Primary Address of Group:**   
(Street Address  
 City, State, ZIP Code)  
 \*No P.O. Box

3. **Plan Administrator/Contact:**

a. Name

b. Title

c. Address   
(If different from primary)  
 City, State, ZIP Code

d. Phone Number     Ext.

e. Fax Number

f. E-mail Address

g. Add'l Contact & Number

4. **Name and title of person to receive billing statements:**

a. Name

b. Title

c. Address   
(If different from primary)  
 City, State, ZIP Code

d. Phone Number     Ext.

e. Fax Number

5. **Nature of Business:**

6. **SIC Code:**

7. **Tax Identification Number:**

## II. ADMINISTRATIVE INFORMATION

The term "coverage" means the benefits provided by Oxford, pursuant to the group Certificate of Coverage.

1. **Effective date:** We request that this coverage be effective: \_\_\_\_\_.  
(Month / Day 1st / Year)
2. **Age of Business:** Please indicate if your business has been in operation:  Less than 12 months  More than 12 months
3. **Other group health or HMO coverage:** Indicate below other group health coverage which is still in force or which terminated within the past three years.

Type of coverage	Name of carrier	Effective date	If terminated, date terminated

**Eligibility & Termination:** The employee will become eligible on the latter of the effective date of this plan or the date selected below (check appropriate date).

4. **Integration with Medicare Benefits:** Health benefits covered by Medicare Part A and B are carved out for retired employees age 65 and over and their dependents age 65 and over if the group offers retiree coverage.

## III. PRODUCT AND PLAN DESIGNS

### A. Oxford Sole Proprietor Plan

**Instructions:** Please select a plan option and check off any variable items as provided below.

Benefit Package	Liberty Network		Freedom Network	
	Plan 1 <input type="checkbox"/>	Plan 2 <input type="checkbox"/>	Plan 3 <input type="checkbox"/>	Plan 4 <input type="checkbox"/>
Product	Direct	EPO	Direct HSA	EPO HSA
PCP Copayment	30/50	25/50	N/A	N/A
In-Network Coinsurance %	80%	90%	90%	100%
Out-of-Network Coinsurance %	60%	N/A	70%	N/A
In-Network Single Deductible	\$2,000	\$2,000	\$2,850	\$2,000
Out-of-Network Single Deductible	\$2,000	N/A	\$2,850	N/A
Family Multiplier	2x	2x	2x	2x
Emergency Room Copayment	\$100	\$75	Deductible and Coinsurance	Deductible and Coinsurance
Prescription Benefit	15/50% with \$100 deductible		15/50% with \$2,850 deductible	15/50% with \$2,000 deductible
Inpatient/Outpatient Facility	Deductible and Coinsurance			
Outpatient Surgical	Deductible and Coinsurance			
Domestic Partner	Same and Opposite			

### B. Other Riders

- Biologically Based Mental Health Services  
 (30 Days Inpatient Care Per Calendar Year)  
 (20 Visits Outpatient Care Per Calendar Year)

## IV. RATE INFORMATION

**Monthly Rates:** All new groups are subject to the four-tier rate structure indicated below. Rates must be included in the spaces below for application processing. **Please note:** All four categories must be completed.

Single	Couple	Parent/Children	Family
\$	\$	\$	\$

## V. BROKER / AGENT INFORMATION

	Broker	Co-Broker	General Agent
1. Name of Broker/Agent :	Washwick Agency, Inc.		
2. Oxford Broker Code (Required):			
3. Social Security # or Federal Tax ID #:			
4. Broker Street Address:	860 E. Main St.		
5. City, State, ZIP Code:	Riverhead, NY 11901		
6. Telephone Number:	631-369-0888		
7. Fax Number:	631-369-0618		
8. E-mail Address:	kathy@washwick.com		
9. Commission Split %:			
10. Oxford Sales Representative:	Amy Bisson-NHSBU		
<b>Comments:</b>			

**\*Important Information Regarding Producer Compensation:**

We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonuses are not reflected in the premium rate but are paid from our general administrative expenses. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also may make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant). Producer compensation is subject to disclosure of Schedule A of the ERISA Form 5500 for customers governed by ERISA and subject to form 5500 filing requirements. We have also taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For general information on our producer payment arrangements, please go to [www.oxfordhealth.com](http://www.oxfordhealth.com). For specific information about the compensation payable with respect to your particular policy, please contact your producer.

## VI. CONSENT

### AUTHORIZATION FOR BROKER TO ACT AS BENEFITS ADMINISTRATOR

The undersigned hereby requests Oxford Health Plans to accept the Broker or General Agent named above as an authorized Benefits Administrator for purposes of processing any enrollment transactions for my company's Oxford Health Plan policy (including, but not limited to, Member enrollments, Member terminations, Member address changes, group contact changes, group address changes, plan renewal changes, and group contract terminations).

This authorization shall be effective immediately and shall (check one only):

\_\_\_\_\_ Remain in place until it is expressly revoked by me in writing.

\_\_\_\_\_ Remain in place until \_\_\_\_\_.  
(Month / Day 1st / Year)

Further, I agree that my company will be bound by the actions performed by the herein-named Broker or General Agent pursuant to this Consent Form. Additionally, I agree that this Consent Form does not authorize anyone to receive individually identifiable health information about any Oxford Member. I acknowledge that I must notify Oxford in writing to void this agreement in the event of a change in my company's Broker of Record.

## VII. COBRA & EXTENSION OF BENEFITS DATA

1. Do you have any individuals currently on COBRA continuation?  Yes  No  
If yes, identify the number of individuals \_\_\_\_\_.
2. Are there any dependents of employees who are currently disabled or in the hospital?  Yes  No
3. What is the length of the prior carrier's extension of benefits period for disabled employees or dependents? \_\_\_\_\_

## VIII. APPLICANT AGREEMENT

This Application and the premium rates proposed by Oxford are subject to Home Office approval, in writing, by Oxford and may change due to differences in actual versus proposed enrollment, selection of benefits, changes in census data or underwriting criteria, or any other changes in underwriting as determined by Oxford. The Applicant hereby acknowledges that this Application does not constitute any obligation by Oxford to offer coverage to the Applicant until such Application is accepted, in writing, by the Home Office of Oxford. The Applicant hereby confirms that it will not cancel any current health coverage it may currently have in anticipation that this Application will be accepted by Oxford, and that Oxford shall have no obligation to provide coverage to the Applicant unless this Application is formally accepted, in writing, by the Oxford Home Office. Further, I hereby certify on behalf of the Applicant that the Applicant has not had a group health policy terminated within the past 12 months due to failure to pay premiums.

Dated at: \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.

Full legal name of firm: \_\_\_\_\_

The above named company confirms that we employ no additional employees, and that the company's gross income totals at least \$25,000.00.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 dollars and the stated value of the claim for each violation.

Oxford Health Insurance, Inc.

X

Signature of Authorized Officer of the Company

Title

Witness

Duly Licensed Resident Agent/Broker



A UnitedHealthcare Company

# NY Member Enrollment Form - Oxford Health Insurance, Inc.

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601 • 1-800-444-6222 Corporate Address: 48 Monroe Turnpike, Trumbull CT 06611 • www.oxfordhealth.com

## TO BE COMPLETED BY EMPLOYER

PLEASE PRINT

NAME OF GROUP (EMPLOYER)	GROUP NUMBER	CONTRACT SPECIFIC PACKAGE (CSP)	BILLING GROUP (BG)
EMPLOYEE'S EFFECTIVE DATE OF COVERAGE / /	IS THIS INDIVIDUAL ENROLLING UNDER COBRA? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, QUALIFYING EVENT	DATE OF QUALIFYING EVENT / /
PRODUCT SELECTED: <input type="checkbox"/> HMO <input type="checkbox"/> FREEDOM <input type="checkbox"/> LIBERTY <input type="checkbox"/> LIBERTY HMO <input type="checkbox"/> OTHER:	IS EMPLOYEE CURRENTLY: ACTIVELY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	ON LEAVE OF ABSENCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	RETIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO
AVERAGE NUMBER OF HOURS WORKED PER WEEK	DATE OF FULL-TIME EMPLOYMENT / /	EMPLOYEE OCCUPATION	UNION/NON-UNION
EMPLOYER SIGNATURE X	DATE / /		

## TO BE COMPLETED BY EMPLOYEE

EMPLOYEE LAST NAME	FIRST NAME & MI	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH / /
STREET ADDRESS	APT. NUMBER	HOME PHONE ( )	BUSINESS PHONE ( )
CITY	STATE ZIP	COUNTY	SOCIAL SECURITY NUMBER
OXFORD PRIMARY CARE PHYSICIAN	OXFORD CODE	IS THIS A NEW PHYSICIAN FOR YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO	
OXFORD OB/GYN PROVIDER (FEMALE MEMBERS)	OXFORD OB/GYN CODE	IS THIS A NEW PHYSICIAN FOR YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO	
TYPE OF COVERAGE: <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY ANY OTHER HEALTH COVERAGE (INCLUDING MEDICARE) WHILE ENROLLED WITH OXFORD? <input type="checkbox"/> PARENT / CHILD <input type="checkbox"/> HUSBAND / WIFE	<input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, CARRIER NAME:	SOCIAL SECURITY NUMBER OF POLICY HOLDER	COVERAGE DATES / / TO / /
LANGUAGE: <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> CHINESE <input type="checkbox"/> OTHER:	COMMUNICATION PREFERENCE (PLEASE RANK IN ORDER FROM 1-4) __MAIL __FAX __PHONE __E-MAIL - ADDRESS:	PREFERRED TIME/ PLACE OF CONTACT <input type="checkbox"/> DAY <input type="checkbox"/> EVENING <input type="checkbox"/> HOME <input type="checkbox"/> OFFICE	

## EMPLOYEE'S DEPENDENT INFORMATION

SPOUSE'S LAST NAME	FIRST NAME & MI	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF MARRIAGE: / /
IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	ANY OTHER HEALTH COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, NAME:	SOCIAL SECURITY NUMBER OF POLICY HOLDER	COVERAGE DATES / / TO / /		
SPOUSE'S EMPLOYER	SPOUSE'S OCCUPATION		DAYTIME PHONE ( )		
OXFORD PRIMARY CARE PHYSICIAN	OXFORD CODE	IS THIS A NEW PHYSICIAN FOR YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO			
OXFORD OB/GYN PROVIDER (FEMALE MEMBERS)	OXFORD OB/GYN CODE	IS THIS A NEW PHYSICIAN FOR YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO			
ELIGIBLE CHILD'S LAST NAME	FIRST NAME & MI	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	AGE:
IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	ANY OTHER HEALTH COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, NAME:	SOCIAL SECURITY NUMBER OF POLICY HOLDER	COVERAGE DATES / / TO / /		
OXFORD PRIMARY CARE PHYSICIAN	OXFORD CODE	IS THIS A NEW PHYSICIAN FOR YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO			
OXFORD OB/GYN PROVIDER (FEMALE MEMBERS)	OXFORD OB/GYN CODE	IS THIS A NEW PHYSICIAN FOR YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO			
ELIGIBLE CHILD'S LAST NAME	FIRST NAME & MI	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	AGE:
IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	ANY OTHER HEALTH COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, NAME:	SOCIAL SECURITY NUMBER OF POLICY HOLDER	COVERAGE DATES / / TO / /		
OXFORD PRIMARY CARE PHYSICIAN	OXFORD CODE	IS THIS A NEW PHYSICIAN FOR YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO			
OXFORD OB/GYN PROVIDER (FEMALE MEMBERS)	OXFORD OB/GYN CODE	IS THIS A NEW PHYSICIAN FOR YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO			
ELIGIBLE CHILD'S LAST NAME	FIRST NAME & MI	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	AGE:
IS THIS DEPENDENT DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	ANY OTHER HEALTH COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, NAME:	SOCIAL SECURITY NUMBER OF POLICY HOLDER	COVERAGE DATES / / TO / /		
OXFORD PRIMARY CARE PHYSICIAN	OXFORD CODE	IS THIS A NEW PHYSICIAN FOR YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO			
OXFORD OB/GYN PROVIDER (FEMALE MEMBERS)	OXFORD OB/GYN CODE	IS THIS A NEW PHYSICIAN FOR YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO			

## RACE/ETHNICITY (OPTIONAL) (THIS INFORMATION IS FOR THE PURPOSE OF DATA COLLECTION AND WILL NOT BE USED FOR DETERMINING ELIGIBILITY, RATING OR CLAIM PAYMENT.)

EMPLOYEE: <input type="checkbox"/> WHITE <input type="checkbox"/> AFRICAN AMERICAN/BLACK <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> ASIAN <input type="checkbox"/> OTHER:	SPOUSE: <input type="checkbox"/> WHITE <input type="checkbox"/> AFRICAN AMERICAN/BLACK <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> ASIAN <input type="checkbox"/> OTHER:
CHILD: <input type="checkbox"/> WHITE <input type="checkbox"/> AFRICAN AMERICAN/BLACK <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> ASIAN <input type="checkbox"/> OTHER:	CHILD: <input type="checkbox"/> WHITE <input type="checkbox"/> AFRICAN AMERICAN/BLACK <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> ASIAN <input type="checkbox"/> OTHER:

**IN ORDER TO HELP US QUICKLY PROCESS THIS FORM AND AVOID DELAYS, PLEASE MAKE SURE ALL AREAS ARE PROPERLY FILLED OUT. IF YOU HAVE ADDITIONAL DEPENDENTS, PLEASE USE ANOTHER ENROLLMENT FORM TO PROVIDE THE NECESSARY INFORMATION.**

I understand that my enrollments and benefits are in accordance with those described in the Oxford Health Insurance Certificate. I understand that, in order to receive in-network benefits, I and any enrolled dependents must seek care through our Oxford affiliated primary care physician or through an Oxford-affiliated specialist physician with an authorized referral from the primary care physician if required. I further understand that if I do not adhere to these requirements, I will be eligible only for out-of-network health insurance coverage under the terms of the Certificate. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

EMPLOYEE/APPLICANT SIGNATURE X	DATE
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# Coordination of Benefits Form

Please submit this form with all supporting documentation to Oxford's Coordination of Benefits Department at:

**Mailing Address:** P.O. Box 7071, Bridgeport, CT 06601-9630 • 1-800-767-3840

## SUBSCRIBER INFORMATION (Please Print Clearly Or Type)

Oxford Subscriber Name: \_\_\_\_\_ Oxford ID Number: \_\_\_\_\_

### Employment Information (Please check the appropriate boxes)

Actively at Work:  Yes  No Total number of employees at company is:  1-19  20-99  100+

Retired:  Yes  No Date of Retirement: \_\_\_/\_\_\_/\_\_\_ Spouse's Social Security Number: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_/\_\_\_/\_\_\_

Spouse's Current Employer/Company Name: \_\_\_\_\_

Spouse's Employer Address/Phone Number: \_\_\_\_\_

## COVERAGE INFORMATION

### Please note: If you, your spouse or dependent(s) have:

- Other coverage, please complete Part A1, then sign and date the form.
- No other coverage, please complete Part A2, then sign and date the form.
- Been divorced/legally separated/single parent, please complete Part B in addition to Part A, then sign and date the form.
- Medicare coverage, please complete Part C, then sign and date the form.

## PART A

### 1. Other Coverage (list each separately)

Carrier Name: \_\_\_\_\_

Carrier Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Policy #: \_\_\_\_\_ Subscriber's SS #: \_\_\_\_\_

Policy Effective Dates: Start \_\_\_/\_\_\_/\_\_\_ End \_\_\_/\_\_\_/\_\_\_ Covered Dependents: \_\_\_\_\_

#### Coverage Type:

(Check applicable)  Hospital  Major Medical  Prescription  Dental  Retiree  COBRA  Other

Carrier Name: \_\_\_\_\_

Carrier Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Policy #: \_\_\_\_\_ Subscriber's SS #: \_\_\_\_\_

Policy Effective Dates: Start \_\_\_/\_\_\_/\_\_\_ End \_\_\_/\_\_\_/\_\_\_ Covered Dependents: \_\_\_\_\_

#### Coverage Type:

(Check applicable)  Hospital  Major Medical  Prescription  Dental  Retiree  COBRA  Other

If the other coverage is no longer in effect, you must enclose documentation from the former carrier indicating the date the policy was terminated.

### 2. No Other Coverage

If your spouse does not have other health coverage, please indicate the reason:  Not married

Benefits not offered  Unemployed  Self-employed  Waived, as of: \_\_\_/\_\_\_/\_\_\_

Part-time employee (not eligible for benefits)  Waiting period, eligible for coverage on: \_\_\_/\_\_\_/\_\_\_

Other, please explain: \_\_\_\_\_

Please turn over

**PART B**

**Please complete this section if you are divorced, legally separated, or a single parent, and you have dependent children covered under this plan.**

1. Does the other biological parent of your dependent children provide health benefits?  Yes  No  
 Name of other biological parent: \_\_\_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_

**If yes, please provide the following information:**

Name of other health plan: \_\_\_\_\_  
 Policy #: \_\_\_\_\_  
 Subscriber's SS #: \_\_\_\_\_  
 Which children are covered? \_\_\_\_\_

2. Are you divorced or legally separated?  Yes  No Date of divorce/separation: \_\_\_/\_\_\_/\_\_\_  
 Are you a single parent?  Yes  No

**If divorced, check one of the following:**

- Divorce decree stipulates other parent must provide health benefits
- Divorce decree stipulates joint custody
- Divorce decree does not stipulate any special provisions
- Other, please explain: \_\_\_\_\_

**\*A copy of the section of the court decree pertaining to health coverage or other documents must be provided to support your response.**

**PART C**

**You should complete this section if you, your spouse, and/or your dependents are eligible for Medicare. Please enclose a copy of the Medicare ID card for each eligible member of your family.**

Name of Member eligible for Medicare: \_\_\_\_\_

Effective Dates of Medicare:  
 Part A: \_\_\_/\_\_\_/\_\_\_ Part B: \_\_\_/\_\_\_/\_\_\_

Reason for Medicare coverage  
 (please check one):

- Age 65 or older
- End Stage Renal Disease (ESRD)

Date Dialysis Treatment Began: \_\_\_/\_\_\_/\_\_\_

Disability, due to: \_\_\_\_\_

Name of Member eligible for Medicare: \_\_\_\_\_

Effective Dates of Medicare:  
 Part A: \_\_\_/\_\_\_/\_\_\_ Part B: \_\_\_/\_\_\_/\_\_\_

Reason for Medicare coverage  
 (please check one):

- Age 65 or older
- End Stage Renal Disease (ESRD)

Date Dialysis Treatment Began: \_\_\_/\_\_\_/\_\_\_

Disability, due to: \_\_\_\_\_

**SUBSCRIBER SIGNATURE**

I certify that the above information is correct and understand that I am obligated to provide this information to Oxford in accordance with the Certificate of Coverage. Failure to provide complete and accurate information may result in a delay in the payment of benefits.

Print Your Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Oxford ID Number: \_\_\_\_\_



A UnitedHealthcare Company

# Student Verification Parent Affidavit Form

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601-9688 • 1-800-444-6222

Welcome to Oxford Health Plans.

To be eligible for student dependent coverage we require verification of full-time student status, please submit verification for the current semester.

Please arrange to have this postage-paid Student Verification Information Form submitted to Oxford at the time of your enrollment.

If your child is not a full-time student, he or she may still be eligible for coverage. For more information, please contact the Benefits Administrator at your company.

If you have any questions, please call our Customer Service Department at 1-800-444-6222.

Sincerely,

Oxford Health Plans

**TO BE COMPLETED BY THE SUBSCRIBER**

\_\_\_\_\_  
Employer Name

\_\_\_\_\_  
Subscriber Name

\_\_\_\_\_  
Subscriber Social Security #

\_\_\_\_\_  
Name of Student

\_\_\_\_\_  
Student Social Security #

\_\_\_\_\_  
Name of School

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

I confirm that the above named dependent is registered as a  full-time  part-time student at an accredited educational institution for the \_\_\_/\_\_\_/\_\_\_ semester, which begins on \_\_\_/\_\_\_/\_\_\_ and ends \_\_\_/\_\_\_/\_\_\_.

I attest that the information shown above is true and complete. I understand that failure to complete this form may result in delayed, denied or termination of coverage for the above named dependent. I understand that Oxford Health Plans reserves the right to request additional information as proof of the above-named dependent's full-time status.

Further, any person who knowingly and with intent to defraud an insurance company or other person files a statement or claim containing any materially false information concerning any material fact thereto, commits a fraudulent insurance act, which is a crime, and is also subject to a civil penalty.

\_\_\_\_\_  
Subscriber's Signature

\_\_\_\_\_  
Date





## HEALTH SAVINGS ACCOUNT (HSA) APPLICATION

To avoid processing delays, please complete all fields on the application — shaded fields are optional, starred fields (\*) are required.

**Mail** your completed application (and opening deposit, if applicable) to:  
Exante Bank HSA, P.O. Box 169049, Duluth, MN 55816

**Or fax** both sides of this form to: 800-765-6766 and mail opening deposit, if applicable, separately to:  
Exante Bank, P.O. Box 271629, Salt Lake City, UT 84127

### PART 1: PERSONAL INFORMATION — ACCOUNT HOLDER

\*Social Security #

*First Name		*Middle Initial	*Last Name	
*Street Address (cannot be a P.O. box)			Mailing Address (if different than street address)	
*City			City	
*State	*ZIP	State	ZIP	
*Date of Birth			*Home phone # with area code	
*Mother's maiden name (or other password for security purposes — 6 to 10 letters)				
Work phone # with area code and extension			E-mail address	

#### PER THE USA PATRIOT ACT:

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. When you open the account, we will ask for your name, street address, date of birth and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

Form of Identification (check one): <input type="checkbox"/> Driver's License <input type="checkbox"/> State ID <input type="checkbox"/> Passport	Identification #	State of issuance
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### PART 2: HIGH-DEDUCTIBLE HEALTH PLAN (HDHP)/MEDICAL PLAN INFORMATION

*Medical Insurance Company or Carrier	*Medical Insurance Plan or Group #
HDHP Member Identification # (you may find this on your ID card)	*HDHP start date
*Who is covered? (check one): <input type="checkbox"/> Individual <input type="checkbox"/> Family [Individual + Dependent(s)]	
*Are you enrolling in an HSA through your employer? (check one): <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide your employer's name	

### **PART 3: REQUEST FOR ADDITIONAL DEBIT CARD (OPTIONAL)**

You will receive a Health Savings Account MasterCard® Debit Card. If you wish to request a Health Savings Account Card<sup>SM</sup> for use by an authorized user — either your spouse or another eligible dependent — please complete the section below.

Authorized User's First Name	Authorized User's Middle Initial	Authorized User's Last Name
Authorized User's Date of Birth	Authorized User's Social Security #	
If address is same as Account Holder, check here <input type="checkbox"/>		
Authorized User's Street Address		
Authorized User's City	Authorized User's State	Authorized User's ZIP

### **PART 4: BENEFICIARY INFORMATION (OPTIONAL)**

If you do not designate otherwise, your estate will be the beneficiary of your HSA upon your death. To designate an alternative beneficiary, please complete a Designation of Beneficiary form, available on ExanteBankHSA.com or request one from customer service, toll-free at 1-866-234-8913.

### **PART 5: REQUIRED SIGNATURES (Please read before signing)**

- I understand the eligibility requirements for deposits made to my Health Savings Account (HSA) and state that I qualify to make deposits to this account. I have reviewed this application, the Health Savings Account (HSA) Schedule of Fees and Charges, HSA Custodial and Deposit Agreement and Privacy Notice. By signing below, I understand and agree to be bound by the terms and conditions that apply to this HSA as outlined in these documents.
- I assume complete responsibility for:
  1. Determining my eligibility for an HSA each year I make a contribution.
  2. Ensuring all contributions made to my account are within the limits set forth by the tax laws.
  3. Any tax consequences of contributions (including rollover contributions) and distributions.
- I authorize Exante Bank to provide information about my HSA, including my account number, to my employer (if applicable), and those acting on behalf of my employer or Exante Bank (if applicable), in connection with the establishment and maintenance of my HSA.
- I acknowledge that my employer, and others acting on behalf of my employer (if applicable), may provide information on my behalf to establish and maintain my HSA.
- I understand that my monthly account statements will be made available to me electronically. I agree to notify Exante Bank if I wish to have statements mailed to my home address.
- I certify that the information provided in this application is true and complete.

X \_\_\_\_\_

\*Account Holder – Signature Required

\_\_\_\_\_ \*Date

**IMPORTANT:** We cannot process this application without your signature.

### **PART 6: OPENING DEPOSIT**

Opening deposit enclosed with application (if applicable) (check one):  Yes  No Amount: \$ \_\_\_\_\_

If you are an individual mailing an opening deposit for your own HSA, please write your name and social security number on the check.



## CUSTODIAL AND DEPOSIT AGREEMENT

### CUSTODIAL AND DEPOSIT AGREEMENT ("Agreement")

The person whose name appears on the Application is establishing with us a Health Savings Account (HSA) qualified under Section 223 of the Code. Funds on deposit in the Account at the Bank are insured by the FDIC up to the limits specified in the Federal Deposit Insurance Act and applicable regulations adopted by the FDIC from time to time.

### DEFINITIONS

**Defined terms are italicized. As used in this Agreement:**

- *Account* means the HSA deposit account you have established with us.
- *Application* means the HSA application.
- *Bank* means Exante Bank, Inc., a Utah state-chartered bank and member of the FDIC, or its successors or assigns.
- *Beneficiary* means the person you have chosen to receive the proceeds of your Account, as shown in the Application or any other form provided by us.
- *Check* means the checks which may be provided to you in connection with your Account.
- *Code* means the Internal Revenue Code of 1986, as amended as of the date of and during the term of this Agreement, and all the rules and regulations in effect or adopted by the United States Internal Revenue Service during the term of this Agreement.
- *Debit Card* means the authorized third party provider access card which may be issued to you, and to an authorized user of your Account, if applicable, by the Bank in connection with your HSA.
- *Disclosure Statement* means the statement provided by us to you describing how you can obtain Investments for your Account.
- *ERISA* is the federal Employee Retirement Income Security Act of 1974, as amended as of the date of and during the term of this Agreement.
- *FDIC* is the Federal Deposit Insurance Corporation.
- *Investments* shall mean such mutual funds as have been accepted by us and made available to you for purchase using funds within the Account as directed by you either through arrangements directly with the mutual fund or through a service provider as provided under the terms of this Agreement, the Disclosure Statement, and the separate terms and conditions contained within the prospectus and statement of additional information relating to the purchase of any specific mutual fund.
  - Investments are not insured by the FDIC.
  - Investments are not guaranteed by us.
  - Investments may lose value.
- *You, your or yours* means the owner of the Account, any spouse beneficiary upon the death of the Account owner, or any third party authorized or appointed to access and use the Account, which third party will be considered the agent of the Account owner.
- *We, us or our* means the Bank, its parent, affiliates, officers, employees, agents and representatives, including but not limited to, subagents, subcustodians and subcontractors.

### OUR RIGHTS AND OBLIGATIONS

As custodian of the *Account*, our sole duties are to:

- Keep accurate and complete records of contributions to, *Investments* made within, and distributions from *your HSA*;
- File any returns and reports imposed by the *Code* upon *us* as HSA custodian; and
- Use ordinary care and reasonable diligence in maintaining *your HSA*.

Upon any assignment of this Agreement or the HSA by *us*, the assignee automatically shall become the custodian of the *Account*. Upon *your* death, *we* will pay any balance in *your Account* (after deducting the amount of any *Debit Card* or other transactions made and related adjustments and chargebacks and any other *Account* fees and charges which may be owing) to the *Beneficiary(ies)* designated by *you* on the *Application*, or as amended by *you* in a written notice to the *Bank*. Notify *us* immediately if *you* wish to change the *Beneficiary*, such as in the case of a change in *your* marital status.

All materials provided by *us* are designed and distributed with the understanding that they do not constitute or include legal, tax, or other professional advice. *We* assume no responsibility for tax or other consequences to anyone arising from the establishment or use of the HSAs. *You* may wish to consult with an attorney or other qualified tax professional. By using the *Account*, *you* acknowledge and agree that nothing in this Agreement is construed to confer fiduciary status upon *us* for any purpose. *We* are not required to perform any additional services or undertake any fiduciary responsibility unless specifically agreed to under the terms and conditions of this Agreement or a separate agreement entered into by and between *you* and the *Bank*.

### YOUR RESPONSIBILITIES

*You* acknowledge and agree that *you* are solely responsible for (i) determining whether *you* are eligible to have an *Account*, and whether distributions from *your Account*, including *Check*, *Debit Card* purchases and other *Account* withdrawals, constitute qualified medical expenses, as defined in the *Code*, (ii) keeping appropriate records for these purposes, (iii) ensuring that all contributions and *Investments* *you* make are permitted under applicable law, (iv) determining the tax consequences of any contributions (including rollover contributions) and distributions *you* make, and any taxes, interest, penalties and other expenses which may be payable under law in connection with *your Account*. *You* agree that *we* are a custodian of *your Account*, and *you* authorize *us* to act without further inquiry in accordance with the instructions given to *us* by *you* or any third party authorized or appointed to act on the *Account*, including any instructions that specify a particular tax year for contributions.

The HSA is self-administered by *you*. *You* cannot assign *your Account*, and *your* interest in *your HSA* is nonforfeitable. Only *you* can authorize withdrawals from *your HSA*. *We* reserve the right to correct errors (whether made by *us* or *your* employer, if applicable) including the right to withdraw any funds that should not have been placed in *your HSA* and to withdraw *Account* administrative fees. *You* may not use the HSA or the assets in it as security for any loan. Neither *you* nor any *Beneficiary* may transfer or pledge any

interest in *your HSA* in any manner whatsoever, except as provided by law or this Agreement. *You* are responsible for complying with all laws governing withdrawals, transfers and taxes. All transfers or distributions from the *Account* must be made in accordance with the *Code*.

If *you* have *your HSA* through *your* employer, *your* employer has permitted *us* to offer *our* services through *your* workplace. The HSA is established pursuant to federal tax law, and is neither endorsed by nor sponsored by *your* employer. Rather, it is an individual *account* arrangement between *you* and *us*. As a result, the HSA is not part of *your* employer's *ERISA* benefit plan, even if *your* employer contributes to it or *you* make pre-tax contributions under *your* employer's cafeteria plan.

By written notice to *us*, *you* can name a *Beneficiary* who will receive any *Investments* held in *our* name or in a nominee name for *your HSA* and any funds on deposit in *your Account* upon *your* death. Upon satisfactory proof of *your* death, *we* will transfer or distribute the entire balance (as required by the *Code*) to *your Beneficiary* or, if none, to *your* estate.

### DEPOSITS AND AVAILABILITY OF FUNDS

Funds on deposit in *your Account* will be available for withdrawal from *your Account* in accordance with *our* standard funds availability schedule. *We* reserve the right to require at least seven (7) days written notice prior to withdrawal of funds from the *Account*. Unless otherwise instructed by *you*, deposits received by *us* during non-business hours will be considered to be made on the next full banking day and *we* may refuse, limit or return any funds received for deposit. *We* accept only funds in U.S. dollars. Funds received in other currencies will be returned to *you*. *You* agree to pay the *Bank's* standard *Account* fees, as in effect from time to time.

### INTEREST AND FEES

*You* will earn interest on the funds on deposit in *your Account* at the rate established by *us*. Interest will accrue daily based on the balance of funds on deposit in *your Account* and will be credited monthly. The interest rate and annual percentage yield on the full balance in *your Account* will be on a tiered basis, as described in a table in the Truth in Savings Disclosure. *Your* interest rate and annual percentage yield (in any or all categories in the table) may change at any time thereafter at *our* discretion, and without notice.

*You* will pay *us* fees for the services *we* perform for *you* in connection with *your HSA*. *You* have acknowledged receipt of *our* schedule of fees as an attachment to this Agreement. *You* authorize *us* to withdraw all fees from the balance in *your Account*. *We* can adjust the amount or type of the fees, or add new fees, from time to time.

### OPERATIONAL ACCOUNTS

In *our* capacity as custodian of the *Account*, *we* may establish and maintain certain record-keeping sub *accounts* for the efficient administration and management of the *Account*. The *Account* may consist of a NOW sub *account* and a savings sub *account* and *we* may periodically transfer funds between these two sub *accounts*. *Your* bank statement will show a single balance representing the total funds in the two sub *accounts*. The same interest rate will apply to both sub *accounts* and interest will be paid on the total *account* balance regardless of how funds are distributed between the sub *accounts*.

### SELF-DIRECTED INVESTMENT PROVISIONS

**Investment of Contributions:** *You* may invest any portion of the contributions to *your Account* in excess of the minimum amount established by *us* as described within the *Disclosure Statement*, including any earnings of such *Investments*, in such amounts as *you* specifically select and direct (or as directed by the *Beneficiary* upon *your* death), in orders to *us* in such form as may be acceptable to *us*, without any duty to diversify and without regard to whether such property is authorized by the laws of any jurisdiction as a trust investment. *We* shall direct all orders received to such service provider as *we* may select for the execution of such orders and *we* shall maintain adequate records thereof. If any such orders are not received as required, or, if received, are unclear in *our* opinion, all or a portion of the contribution may continue to be held as funds on deposit in *your Account* without liability for loss of income or appreciation, and without liability pending receipt of an acceptable order or clarification. *You* acknowledge and agree that prior to submitting an order, *you* shall have received, read and understood the prospectus describing the *Investments* and all fees and expenses relating to such purchase. All purchases of the *Investments* shall be made according to the terms and conditions of the then-effective prospectus relating to the *Investments* and any statement of additional information as such documents may be amended and updated in accordance with applicable law. *We* shall have no duty other than to follow *your investment* directions and shall be under no duty to question said instructions and shall not be liable for any *investment* losses sustained by *you*. *We* shall not make any *investment* or dispose of any *investment* except upon the express verbal or written direction from *you*, except as provided in this Agreement. *You* acknowledge that any liquidation of *Investments* will not result in immediately available funds for deposit to *your Account* and such funds will be available only in accordance with the terms and conditions applicable to the specific *investment* made by *you* and the terms and conditions of the *Account* regarding availability of funds.

**Registration:** All *Investments* shall be registered in *our* nominee name or a suitable nominee. The same nominee name may be used with respect to assets of other HSA *accounts* whether or not held under agreements similar to this one or in any capacity whatsoever. However, *we* shall maintain a separate accounting of the *Investments* registered in *our* nominee name for the benefit of *your Account*.

**No Investment Advice:** *We* do not assume any responsibility for rendering advice with respect to the *investment* and reinvestment of the funds on deposit within *your Account* and shall not be liable for any loss which results from *your* exercise of *investment* control over *your Account*. *You* (or as directed by the *Beneficiary* upon *your* death) shall have and exercise exclusive responsibility for control over the *investment* of any funds within the *Account*, and *we* have no duty to question the *investment* directives provided by *you*.

**Disclosures and Voting:** *We* shall deliver, or cause to be executed and delivered, to *you* all notices, prospectuses, financial statements, proxies and proxy soliciting materials relating to *Investments* held for the benefit of the *Account*. *We* shall not vote any

*Investments* or take any other action, pursuant to such documents, with respect to such assets except only in accordance with such directions *you* provide to *us* regarding any such vote.

**Miscellaneous Expenses:** *You* agree to pay any and all expenses incurred in connection with any *Investments* made for the benefit of the *Account* and any transfer taxes incurred in connection with the *investment* or reinvestment of the assets of the *Account*. The *Bank* will not charge *you* a fee for placing and administering an *investment you* direct *us* to make in a mutual fund. However, the mutual fund will charge fees for management, administrative services, and other expenses of the fund, which are disclosed in the prospectus. The *Bank* may receive a portion of the shareholder servicing fee from a mutual fund for recordkeeping and other services provided in connection with *your investment*, but such shareholder servicing fee does not represent an additional fee or charge to *you*.

#### WITHDRAWALS

*You* may withdraw all or any part of the balance of *your Account* at any time. *You* are solely responsible for the tax treatment of any withdrawals from the *Account*, whether made by *Check*, *Debit Card* or third party transfer from *your Account*.

If available on *your Account*, *we* may provide *you* or an authorized user with *Checks* to enable *you* or an authorized user to make withdrawals. *You* understand that *we* will not return original *Checks* to *you*. Processed *Check* images will be made available to *you* on *our* Web site. *We* are not responsible for actions taken by other banks, or for the loss or destruction of any *Checks*, drafts or other instruments in the possession of other banks or in transit. *We* may return unpaid any *Check* on *your Account* which is not on a form *we* provided to *you* or an authorized user, or which is presented to *us* before its date. *We* will not be responsible for paying or certifying postdated *Checks* on *Accounts*. *You* may ask *us* in writing to stop payment on a *Check* drawn on *your Account* which has not yet been paid by *us*. *We* will honor any written stop payment request from *you* which is received by *us* at least two business days before the *Check* is presented to *us* for payment. The stop payment order must specify the exact amount of the *Check*, the payee, the date of the *Check*, the number of the *Check* and *your Account* number. *We* will honor the stop payment request for six months.

If available on *your Account*, *you* also may request *us* to issue a *Debit Card* to *you* and to any authorized user on the *Account*, which will enable *you* and such authorized user to pay for purchases from *your Account*. *You* authorize *us* to debit *your Account* to pay for transactions made with *your Debit Card* or a *Debit Card* issued to an authorized user on *your Account*. *You* agree that in addition to this Agreement, the use of a *Debit Card* by *you* or any authorized user on *your Account* is subject to the terms and conditions of the Card Agreement which has been provided to *you* and which is incorporated herein by reference.

Unless otherwise directed by *you* in accordance with the notice provisions herein below, *we* will, where applicable, withdraw required payment amounts from the balance in *your Account* and apply such amounts to any line of credit granted to *you* by *us* in accordance with *your* election under such line of credit agreement. This authorization shall remain in effect until revoked at any time by *you* by giving ten (10) days prior written notice to *Bank* at Exante Bank, PO Box 271629, Salt Lake City, Utah 84127-1629. *You* understand that *we* may continue to make required line of credit payments pursuant to this authorization until expiration of said ten (10) day notice period.

#### THIRD-PARTY TRANSFERS

*You* may authorize *us*, from time to time, on *your* behalf, to make transfers of funds to third parties in the amounts specified by *you*, and to debit *your Account* for the amount of each such payment *we* make. *You* understand *we* will also debit *your Account* for the applicable service charge which is then in effect, and which *we* may change from time to time. *You* understand that in performing this service, *we* will make these payments by *Check* or draft, and that *we* will be acting as *your* agent in making such payments. *We* will not be liable for any errors or delays in making any such payment, except for errors or delays caused by *our* gross negligence, or for *our* inability to make any payment due to circumstances beyond *our* control or if there are insufficient funds in *your Account* with which to make the payment.

#### INSUFFICIENT BALANCE

*You* must maintain a balance in *your Account* which is sufficient to cover all *Checks you* write, *Debit Card* transactions *you* make, and transfers *you* authorize *us* to make on *your* behalf. If there are insufficient funds in *your Account* to cover any such *Check* or *Debit Card* transaction or transfer, *we* may refuse to honor the *Debit Card* transaction or transfer, or return the *Check* without paying it, as the case may be. If *we* make a transfer or pay a *Check* or *Debit Card* transactions against insufficient funds or uncollected balances, *you* agree, promptly on demand, to pay to *us* the amount by which the *Check* exceeds the funds in *your Account*. *You* may be charged interest at *our* rates in effect from time to time on the insufficient balance for each day it is outstanding, and the fee specified on *our* Schedule of Fees. *You* authorize *us* to liquidate *Investments*, at *our* discretion, to cover any insufficient funds in *your Account*.

#### ELECTRONIC SIGNATURES

In the event that *we* have received *your* electronic signature in connection with *your Account Application*, *we* may rely on such electronic signature for purposes of *your* authorization of withdrawals or third party transfers, *your* notices to change *your* name or address or *your* other instructions to *us*. *We* are not required to obtain *your* physical signature for such purposes or any other purpose, except as may be required by law.

#### OTHER INFORMATION AND CHANGE OF NAME OR ADDRESS

Subject to ordinary care and usual practices, *we* are entitled to rely upon information *we* receive with respect to *your* HSA, including the information contained in the *Application*, and have no obligation to make further investigation, except as required by law.

*You* agree to notify *us* promptly, in writing, if *you* change *your* name or address by calling customer service and requesting an address change form.

*You* agree to immediately notify *us* of any changes in the information provided to *us* that *we* rely on in connection with *your Account*. *You* agree to provide *us* with any necessary

information *we* may need to prepare reports required by the *Code* or other laws and regulations.

#### CHANGES IN THIS AGREEMENT

The rights, duties and obligations of both *you* and *us* with regard to *your* HSA are governed by this Agreement and the Card Agreement, as they may be amended from time to time. *We* may amend this Agreement at any time. *We* will provide prior notice of any amendments when *we* are required to do so by law. Additionally, the *Bank*, reserves the right to assign *your* HSA without *your* prior consent, provided that such assignee is qualified under the *Code* to be an HSA custodian or trustee. Upon any assignment of this Agreement, the assignee shall automatically become custodian of the *Account* if it is qualified under the *Code*, to serve as an HSA custodian or trustee. *You* acknowledge that such assignment may result in loss of *FDIC* insurance coverage for any HSA balances for which such assignee becomes a custodian or trustee.

#### NOTICES

Any notice required by this Agreement to be given by *us* to *you* will be effective upon *our* deposit of the notice with the United States Postal Service with proper postage affixed and directed to the last address *you* provided *us*. Any notice required by this Agreement to be given by *you* to *us* will be effective upon receipt of the notice at Exante Bank, P.O. Box 271629, Salt Lake City, UT 84127-1629.

#### ARBITRATION

Any claim or controversy that is not resolved by the parties shall, at the request of a party, be resolved by binding arbitration in accordance with the applicable commercial arbitration rules of the American Arbitration Association. In no event may arbitration be initiated more than one year following the date the dispute arose. Any arbitration proceeding under this Agreement shall be conducted in Salt Lake City, Utah. The arbitrators may construe or interpret, but shall not vary or ignore the terms of this Agreement, shall have no authority to award extra contractual damages of any kind, including punitive or exemplary damages, and shall be bound by controlling law. Judgment upon an arbitration award may be entered in any court of competent jurisdiction. The parties acknowledge that because this Agreement affects interstate commerce, the Federal Arbitration Act applies.

#### STATEMENTS

Upon receipt of a signed *Application* or other *bank* approved affirmation from *you*, *we* will make available electronically for *you* a monthly statement or statements summarizing each transaction in *your Account* during the preceding month. *We* will mail or deliver a statement or notice to *you* upon request. *You* agree to examine each statement or notice after it is posted on the Web site or sent to *you*. If *you* discover any unauthorized transactions, or signatures or alterations, or other discrepancies on *Checks* or *Debit Card* transactions, *you* must promptly notify *us* in writing of the relevant facts. *You* agree that if *you* do not report any discrepancies within sixty (60) days of when *we* first send the statement or make it available to *you*, the statement will be deemed correct and *you* will not be able to assert a claim against *us*.

#### DEFAULTS

*You* will be in default if *you* fail to meet any of *your* obligations under this Agreement or any other agreement with *us*. In the event of a default, *we* may exercise any legal rights *we* may have. If *we* are required to take any legal action under this Agreement, *you* agree to pay *our* court and collection costs and any attorney's fees and disbursements. If *you* are in default of this Agreement, or upon the closure of the HSA, whether such closure was made by *you* or by *us*, *we* shall not be obligated to continue to provide services under this Agreement.

#### ACCOUNT CANCELLATION AND SUSPENSION

*We* may close the *Account* at any time. *You* may close the *Account* by notifying *us* in writing. No closure of the *Account* will affect *our* right to debit the *Account* for any withdrawals or charges made by *you*, or made by an authorized user of *your Debit Card*, or to honor any adjustments or chargebacks related to such transactions.

As soon as practical after termination, *we* will distribute the balance in *your Account* in accordance with the *Code*. After distribution of all funds, this Agreement will end and *we* will have no further duties, obligations, or liabilities to *you* or anyone, except as required by law.

#### LIMITATION OF LIABILITY/HOLD HARMLESS

In connection with this Agreement and *your* HSA, *we* are not responsible for any act or failure to act by *us* that is reasonable under the circumstances or that is consistent with the rules and regulations of the Board of Governors of the Federal Reserve System and other federal regulatory agencies, or any applicable laws, rules or regulations of the State of Utah, or with general commercial practices of banks. *We* are not responsible for any act or failure to act of any service provider or mutual fund relating to the *Investments*. *You* agree to indemnify *us* and hold *us* harmless against any claims, damages, expenses and losses, including attorney's fees, incurred by *us* resulting from (i) any action *we* take in honoring *your* instructions, including but not limited to all verbal or facsimile instructions received with respect to *your* HSA, (ii) in connection with *our* honoring of any subpoena or court order relating to *your* HSA or (iii) other costs, expenses or liabilities arising under this Agreement except costs, expenses or liabilities that arise from *our* breach of any duty under this Agreement.

#### MISCELLANEOUS

*We* can choose not to exercise or to delay enforcement of any of *our* rights under this Agreement without compromising them. Each party's rights and obligations under this Agreement will be binding upon its heirs, executors, legal representatives, successors and permitted assigns. If any provision of this Agreement is held invalid or unenforceable, all other provisions of this Agreement shall remain in full force and effect. This Agreement becomes effective upon the opening and funding of *your Account*. This Agreement shall be governed by and construed in accordance with the laws of the State of Utah and applicable federal law.