

DESIGNATION OF AN AUTHORIZED SIGNER (NOT AVAILABLE ON HSA CDs)

Since government regulations only allow Health Savings Accounts to be opened under individual ownership, the account owner may want his/her spouse and/or another third party to be added as an **Authorized Signer** so that he/she may also transact on the account. By signing below you are designate the following individual as an Authorized Signer on your Health Savings Account.

Personal Information:

HSA Account Holder's Name: _____	HSA Account Number: _____
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**PLEASE PROVIDE THE FOLLOWING INFORMATION FOR THE AUTHORIZED SIGNER.
ALL INFORMATION HIGHLIGHTED WITH * IS REQUIRED.**

*Name of Authorized Signer: _____	
*Home Street Address: _____	
*Social Security Number: _____	*Birth Date: _____
*Form of Identification: <input type="checkbox"/> Driver's License <input type="checkbox"/> State ID <input type="checkbox"/> Passport	
*ID Number: _____	*State of Issue: _____
*Issue Date: _____	*Expiration Date: _____
Mother's Maiden Name: _____	
City of Birth: _____	State of Birth: _____

I authorize American Chartered Bank to issue an additional Visa Check Card on my account to the authorized signer designated above. I agree to be jointly and severally liable for the performance of the obligations set forth in the Visa Check Card Agreement, to be sent with the card. I acknowledge I will be liable for the use of the Visa Check Card by the authorized signer. **Limit 2 free cards per account. Your HSA account will be charged \$5.00 for each additional card.**

Signature of HSA Account Owner: _____

Date: _____

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HEALTH SAVINGS ACCOUNT SIGNATURE CARD

1. Complete and sign the signature card below.
2. **Both** the HSA account owner and the Authorized Signer must sign the signature card.
3. Mail both pages of this form to the address listed below.

AMERICAN CHARTERED BANK			
HSA CUSTOMER NAME	DATE	# OF SIG REQ. One	ACCOUNT NUMBER
HSA ACCOUNT OWNER'S ADDRESS		TYPE OF ACCOUNT HEALTH SAVINGS	
HSA ACCOUNT OWNER'S SIGNATURE		SOCIAL SECURITY #	
AUTHORIZED SIGNER'S SIGNATURE		SOCIAL SECURITY #	
<p>The depositor acknowledges receipt of a copy of the rules or regulations regulating this account and agrees to be bound by them and by any amendments to them. The depositor has read and certifies under provision of perjury to the truthfulness of the tax withholding certificate appearing below. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding. Signatures shown above are specimen or facsimile signatures of person(s) authorized to effect transactions on this account by the current depository resolution that filed with the Bank. If Single Name Account: This account is owned by the party named hereon.</p> <p>TAX WITHHOLDING CERTIFICATE: Under penalties of perjury, the depositor certifies (1) that the tax identification number shown on this form is the depositor's correct tax payer identification number and that (2) the depositor is not subject to backup withholding either because (a) the depositor is exempt from such withholding, (b) the depositor has not been notified that the depositor is subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the Internal Revenue Service has notified the depositor that the depositor is no longer subject to backup withholding. **Strike the part (2) of this paragraph if the depositor has been notified that the depositor is subject to backup withholding due to underreporting and has not received a notice from the Internal Revenue Service that backup withholding has terminated.</p> <p>I authorize American Chartered Bank to release to my employer account related information necessary to support the posting of electronic credits to my Health Savings account including account number, SSN and bank routing information.</p>			

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Mail Both Pages of This Form To:
 American Chartered Bank - HSA Processing
 PO Box 5994
 Carol Stream, IL 60197-5994
 Phone (847) 407-2603 Fax (847) 407-2633