American Chartered Bank

Health Savings Account Electronic Funding Authorization Form

STEP 1. Depository Bank Information (Bank where funds will be withdrawn)

Account Owner's Name:	**Account Owner's Social Security Number:**

Account Number:	**Depository Bank Name & Address:**
Account Type: (Choose One)	
☐ Checking ☐ Savings	

STEP 2. American Chartered Bank HSA Checking Account Information

HSA Account Owner's Name:	**HSA Checking Account Number:**

STEP 3. Recurring Transfer Instructions

	Frequency:	Enter Amount of Transfer:	Choose Transfer Date:
I am not currently participating in the Direct Debit Program ☐ ADD – Add a recurring transfer to the HSA account shown above. Complete the amount and date fields to the right. I am currently participating in the Direct Debit Program ☐ CHANGE - Change financial institutions and/or account number ☐ CHANGE – The transfer amount and/or transfer date ☐ STOP – Stop any further transfers (allow two weeks for processing)	☒ Monthly	$ __________________	☐ 1st of month, or ☐ 15th of Month

STEP 4. Attach Supporting Document

For transfers from a CHECKING account: ☐ Staple a voided check, from the account to be debited, to this form. (Page 2 not required)
For transfers from a SAVINGS account: ☐ Attach page 2 of this document, signed by you and a representative of your financial institution, to this form.

STEP 5. Read and Sign Below.

By signing below I hereby authorize American Chartered Bank (hereinafter referred to as BANK) to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entry originated in error, to my account at the financial institution named above, hereinafter called DEPOSITORY, to credit and/or debit the same to such amount. This authority shall remain in full force and effect until BANK has received written notification from me (or an authorized signer) of its termination in such time and in such manner as to afford BANK and DEPOSITORY a reasonable opportunity to act upon it.

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 all contribution and distributions.

Important information about deposits to your HSA: The intention of this form is to fund your HSA account on a recurring basis. All electronic deposits are reported as regular contributions for the tax year in which they are received in the account. All other types of HSA contributions must be made by check using the appropriate HSA deposit or transfer forms.

Please allow two weeks for BANK and DEPOSITORY processing.

HSA Customer Signature(s):
(date)

STEP 5. Mail or Fax form(s) to American Chartered Bank

American Chartered Bank
HSA Processing
PO Box 5994
Carol Stream, IL 60197-5994 Fax (847) 407-2633

American Chartered Bank

Health Savings Account
Electronic Funding Authorization Form

Request for Verification of Deposit Account:
(This page is not required if you have attached a voided check to page 1 of the document.)

Privacy Act Notice: This information is to be used by American Chartered Bank or its assignees to verify the information you provided instructing us to initiate recurring debits against an account you maintain at another financial institution. It will not be disclosed outside of American Chartered Bank or its assignees except as required or permitted by law. You do not have to provide this information, but American Chartered Bank cannot initiate the recurring transfers you have requested without it.

Depository Instructions: Please complete items 5 through 12 and return directly to American Chartered Bank at the address provided below. This form is to be transmitted directly to American Chartered Bank, and is not to be transmitted through your account holder or any other party.	**Bank Phone Number:** (847) 407-2603

Part I – Request

1. To (name and address of depository bank)	2. From (Name and address of verifying bank) **American Chartered Bank – HSA Processing Dept.** **PO Box 5994** **Carol Stream, IL 60197-5994**

To Depository Bank: I am the owner of a Health Savings Account at American Chartered Bank, and have requested the Bank to initiate recurring automated clearinghouse (ACH) debits to the account listed below. You are authorized to verify the information on this form, and to supply American Chartered Bank with the information requested by completing sections 6. through 14. in the Verification of Depository section below. Your response is solely a matter of courtesy, and no responsibility is attached to your institution or any of your officers.

3. Name and Address of Account Holder	4. Signature of Account Holder
5. Account Number at Depository Bank	

To Be Completed by Depository Bank

Part II – Verification of Depository Bank Account

Type of Account	Account Number	Current Balance	Average Balance for Previous Two Months	Date Opened

6. Routing and Transit Number through which Depository Receives ACH Transactions

7. If the name on the account differs from the name listed in box 3., please supply the name(s) on the account as listed in your records.

8. Is the individual whose signature appears in box 4. authorized to initiate debit transactions against the account described in box 5?

☐ Yes ☐ No

Part III – Authorized Signature

9. Signature of Depository Representative	10. Title (please type or print)	11. Date
12. Please print or type name of representative who signed in box 9.	13. Phone Number	