

Health Savings Account Application

Name _____
Address _____

Social Security Number _____

Date of Birth _____

Phone _____ - _____

Chexsystems Authorization: _____
*by signing above you authorize Logansport Savings Bank to verify
your banking history through third party verifier Chexsystems*

Authorized Signer? (ie. spouse, qualified dependent)

SIGNER #1:

Name _____

Address _____

Social Security Number _____

Date of Birth _____

Phone _____

Chexsystems Authorization: _____
*by signing above you authorize Logansport Savings Bank to verify
your banking history through third party verifier Chexsystems*

Relationship to owner _____

Authorized Signer? (ie. spouse, qualified dependent)

SIGNER #2:

Name _____

Address _____

Social Security Number _____

Date of Birth _____

Phone _____

Chexsystems Authorization: _____
*by signing above you authorize Logansport Savings Bank to verify
your banking history through third party verifier Chexsystems*

Relationship to owner _____

Plan Coverage

HEALTH INSURANCE PLAN ___ Self-Only ___ Family

Beneficiary Information*Primary Beneficiary*

Percentage	Name	Social Security #	Date of Birth	Relationship
_____ %	_____	_____	_____	_____
_____ %	_____	_____	_____	_____
_____ %	_____	_____	_____	_____
100%				

Contingent Beneficiary

Percentage	Name	Social Security #	Date of Birth	Relationship
_____ %	_____	_____	_____	_____
_____ %	_____	_____	_____	_____
_____ %	_____	_____	_____	_____
100%				

Please initial here _____ if you would like a Debit Card with this Account in addition to checks.

Please supply a photo-copy of Indiana Drivers License or Indiana Identification and a 2nd form of ID (ie. Social Security card OR Major Credit Card for owner/participant and all signers)

X _____
Signature

NOTE: A separate form must be completed & signed by HSA owner & each Authorized Signer

DEBIT CARD APPLICATION /MAINTENANCE

LAST NAME	FIRST NAME	MIDDLE INITIAL
STREET ADDRESS	APT NUMBER	PO BOX
CITY	STATE	ZIP CODE
()		
DAY TIME PHONE NUMBER	SOCIAL SECURITY NUMBER	

CONFIRM ADDRESS *(office use only)*

STREET ADDRESS		
CITY	STATE	ZIP CODE

PLEASE CHECK ONE OF THE FOLLOWING *(office use only)*

CLOSE CARD NUMBER _____

<input type="checkbox"/> CARD LOST/STOLEN	<input type="checkbox"/> CARD DAMAGED
<input type="checkbox"/> CLOSED ACCOUNT	<input type="checkbox"/> OTHER
<input type="checkbox"/> ISSUE NEW CARD	<input type="checkbox"/> RE-ISSUE CARD

ACCOUNTS TO BE LINKED

ACCOUNT NUMBER	TYPE OF ACCOUNT
ACCOUNT NUMBER	TYPE OF ACCOUNT

ORDER NEW PIN NUMBER

CUSTOMER'S SIGNATURE	DATE
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OFFICE USE ONLY

CHECK NOTES _____ (PROCESSING DATE-INITIALS)

DISCLOSURE GIVEN _____

ADDITIONAL REMARKS:

FORM TAKEN BY _____ FEE CHARGED _____

NOTE: A separate form must be completed & signed by HSA owner & each Authorized Signer

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