



2. Investing in a Fulton Bank HSA Fund Advantage Account is not a requirement and that investing in mutual funds involves risks, and that I may instead choose to invest in a Fulton Bank HSA Debit Card Account and earn interest from Fulton Bank.
3. Fulton Bank is not a registered investment advisor, nor is it acting in the capacity of a registered investment advisor with respect to the offering of Fulton Bank HSA Fund Advantage Accounts, but that Fulton Bank has retained Fulton Financial Advisors, N.A. (“FFA”), an affiliate, to select the mutual funds available for HSA Fund Advantage Accounts. Furthermore, I understand that under no circumstances is Fulton Bank or FFA offering any of the mutual funds available for the HSA Fund Advantage Accounts, that neither Fulton Bank nor FFA is making any representations or warranties with respect to any of the available funds, and that Fulton Bank and FFA disclaim any and all liability, contingent or otherwise, for the performance of the available mutual funds.
4. Past fund performance is no guarantee of future results.
5. Share price, yield and return will vary and I may have a gain or loss when I sell my shares.

I have authority and the legal capacity to purchase mutual fund shares, am of legal age, and believe each such investment is suitable for me. It is my responsibility to obtain and read the prospectus of any fund into which I exchange.

I understand that I must designate one fund as my Primary Fund and that all subsequent contributions to and withdrawals from my HSA Fund Advantage Account will be made through this fund. My Primary Fund selection is indicated below: (Please choose **only one fund** from the choices on our web page):

Primary Fund Name: \_\_\_\_\_ Symbol \_\_\_\_\_

### Health Savings Account Statement Options

Unless otherwise agreed, all Health Savings Account/HSA Fund Advantage Account statements will be sent by e-mail [**describe format and/or typical file size**] to the email address above and all Health Savings Account/HSA Debit Card Account statements will be sent by regular mail (U.S. Postal Service) to the address above.

I request that all Health Savings Account/HSA Fund Advantage Account statements be sent to me by regular mail.

### Terms and Conditions and Fees

By signing below, I agree to the following provisions:

1. I certify that I am covered by a qualified High Deductible Health Plan (HDHP) as defined by the Internal Revenue Code (Code), I am not covered by a health plan, other than a HDHP, which provides any of the same benefits as the HDHP, I am not entitled to benefits under Medicare, and I may not be claimed as a dependent on another person’s tax return.
2. I hereby appoint Fulton Bank as custodian for my Health Savings Account (HSA) and I authorize Fulton Bank to provide the information on this Enrollment Form to Health Savings Administrators, LLC and its successor(s), if any, so that they can provide administrative services for my HSA. Administrative services include, but are not limited to, providing enrollment assistance, processing contributions, processing distributions (payments or reimbursements), and submitting tax reports. I acknowledge that the administrative services provided by Health Savings Administrators and its successor(s), if any, are separate and apart from the custodial services provided by Fulton Bank.
3. I agree to an Initial Set Up Fee of \$20.00 and an Annual Administration Fee (for administrative services) of \$36.00 for my HSA. I understand that other fees will be assessed and that those fees depend on the investment option I have selected. I agree to the fees for the HSA Debit Card Account that are disclosed in the Supplemental Terms, Conditions and Disclosures for HSA Debit Card Accounts. I understand that those fees include, but are not limited to, an Annual Maintenance Fee (for custodial services) of \$24.00. I agree to the fees for the HSA Fund Advantage Account that are disclosed in the Supplemental Terms, Conditions and Disclosures for HSA Fund Advantage Accounts. I understand that those fees include, but are not limited to, a quarterly fee of .0009 times the account balance. I recognize that my employer may pay some or all fees. Should I terminate my employment, I will be responsible for payment of all prevailing fees.
4. I authorize Fulton Bank to act on my behalf for all transactions, to honor all distributions (payments or reimbursements) requested by me, and to debit from my HSA any unpaid fees that are due.
5. I am responsible for determining my eligibility for making contributions to my HSA, for ensuring that those contributions are within the limits set forth by the Code, and for all tax consequences of any contributions and any distributions (payments or reimbursements).
6. **I have received and read a copy of (a) this Enrollment Form, (b) the Health Savings Account Custodial Account Agreement, (c) the Additional Provisions for Health Savings Accounts, which includes the Arbitration Provision referred to above (with an explanation of how and when the Arbitration Provision will become effective if I do not reject it) and a Privacy Statement and Consumer Privacy Notice (with an explanation of how and when Fulton Bank shares nonpublic personal information with affiliates unless I direct it not to do so), (d) the Supplemental Terms, Conditions and Disclosures for HSA Debit Card Accounts (even if this is not the investment option I chose), and (e) the Supplemental Terms, Conditions and Disclosures for HSA Fund Advantage Accounts (even if this is not the investment option I chose). I understand that the terms and conditions that apply to this HSA are contained in those documents. I agree to be bound by those terms and conditions.**

**Beneficiary Information**

The following individual(s) or entity shall be my primary and/or contingent beneficiary(ies). If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary beneficiary. If more than one primary beneficiary is designated and no distribution percentages are indicated, the beneficiaries will be deemed to own equal percentages in the account. Multiple contingent beneficiaries with no percentage indicated will also be deemed to share equally. If any primary or contingent beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage of any remaining beneficiary(ies) shall be increased on a pro-rated basis. If no primary beneficiary(ies) shall survive me, the contingent beneficiary(ies) shall acquire the designated percentage(s) of my account.

Name	Relationship	DOB	SSN	Primary or Contingent	% of benefit

**Signature**

*Under penalties of perjury, I certify that the Social Security Number shown on page one of this Enrollment Form is my correct taxpayer identification number, I am a U.S. person (including a U. S. resident alien), and that (check appropriate box):*

- I am not subject to backup withholding either because I am exempt from backup withholding, or because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or because, the IRS has notified me that I am no longer subject to backup withholding.
- I am subject to backup withholding

I understand the eligibility requirements for the type of HSA contribution I am making and confirm I qualify to make the contribution. I hereby hold Fulton Bank, Fulton Financial Advisors, N.A., Health Savings Administrators, LLC and their officers, employees, agents and subcontractors harmless from any liability for effecting transactions and interpreting the tax status of all contributions and distributions (payments and reimbursements). Purchases made with the Debit Card will be reported by Fulton Bank as "normal distributions." I understand I should not use my Debit Card or checks for non-qualifying or non-medical purposes and that I am responsible for any IRS penalties. I understand that I am responsible for any and all tax consequences should I submit an HSA withdrawal form for any non-qualifying or non-medical transaction.


Signature \_\_\_\_\_

Date \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**THE AGREEMENT GOVERNING MY HEALTH SAVINGS ACCOUNT WILL INCLUDE AN ARBITRATION PROVISION UNLESS I ACT WITHIN 30 DAYS TO REJECT THE ARBITRATION PROVISION. ARBITRATION WOULD HAVE A SUBSTANTIAL EFFECT ON MY RIGHTS IN THE EVENT OF A DISPUTE BETWEEN YOU AND ME. FOR EXAMPLE, IN A DISPUTE SUBJECT TO ARBITRATION, I WILL NOT HAVE A RIGHT TO A JURY TRIAL OR TO BRING OR PARTICIPATE IN A CLASS ACTION.**

**Calculations**

One Time Set Up Fee	\$ 20.00
Annual Administration Fee	\$ 36.00
Initial Contribution to Open HSA – Indicate Year of Contribution _____ (required)	\$
Total of Fees and Initial Contribution	\$

**NOTE: Please make check payable to Fulton Bank** 

**Please mail this form, along with the check, to:**

Fulton Bank – c/o Health Savings Administrators, LLC – 10800 Midlothian Turnpike, Suite 240 – Richmond, VA 23235