Instructions: Use this form to change an existing/already established Health Savings Account (HSA). Complete this form and mail it to Avidia Bank, P.O. Box 161390, Altamonte Springs, FL 32716. For assistance, call 1.855.472.9399 or send an email to HSA@avidiahealthcaresolutions.com

Account Holder's Personal Information:

First Name		MI		Last Name			
Street Address		City		State		Zip	
Mailing Address		City		State		Zip	
Date of Birth (mm/dd/yyyy)		Social Security #	- -	Married ☐	(or) Single ☐		
Phone Number		Email					
License Number		Issue State		Expiration Date (mm/dd/yyyy)			

If you do not have a license then provide alternative

State ID Number		Issue State		Passport Number		Country	
Military / Govt ID Number				Other ID Number			

Insurance Coverage Level	Single ■ Family ☐		Employee ID		
Employer Name		Employer City		Employer State	

Authorized Signer: Optional

If you wish to designate an authorized signer on your account, please complete all of the required fields below. If you are unable to provide all of the required information on your authorized signer, he or she will not be added to your account. You hereby designate the following individual as an authorized signer on your Health Savings Account (HSA). By designating an authorized signer on your account, you authorize the person designated above as "Authorized Signer" to transact business with and give instructions to Avidia Bank regarding your HSA; make deposits or withdrawals by any means acceptable to Avidia Bank, including paper and electronic methods such as ACH and Internet-generated transactions; receive and have access to account information, including balances and transactions; endorse any instruments such as checks, orders or other documents for the payment of funds; and to otherwise serve as agent for your Avidia Bank HSA. You specifically authorize Avidia Bank, as custodian of your HSA, to rely upon this authorization and designation until such time, if any, that Avidia Bank receives a written revocation of this authorization, and has had a reasonable time to act upon the revocation. You understand that you are responsible for ensuring that your authorized signer reads and understands the Avidia Bank Account Documents which have been provided to you. You hold harmless and indemnify Avidia Bank against any claims against or losses Avidia Bank may suffer arising out of Avidia Bank's reliance on this authorization, and release Avidia Bank from any liability arising from such reliance, unless otherwise prohibited by law. You understand that you bear sole responsibility for any tax consequences that result from any actions taken by the authorized signer regarding your account. NO PRESENT OR FUTURE OWNERSHIP OR RIGHT OF SURVIVORSHIP IS GIVEN TO THE AUTHORIZED SIGNER BY THIS AUTHORIZATION. UPON NOTICE TO AVIDIA BANK OF YOUR DEATH, THIS AUTHORIZATION TERMINATES, AND RIGHTS TO FUNDS IN YOUR ACCOUNT WILL BE TRANSFERRED TO YOUR BENEFICIARIES. IF YOU DID NOT NAME A BENEFICIARY, YOUR ACCOUNT BALANCE WILL ONLY BE PAYABLE TO YOUR ESTATE.

First Name		MI		Last Name			
Street Address		City		State		Zip	
Relationship		Date of Birth (mm/dd/yyyy)		Social Security #	- -		
Phone Number							

By signing below, I certify that:

- I am, or will be covered by a qualified High Deductible Health Plan (HDHP), I am not enrolled in Medicare or covered under other health insurance that is not compatible with an HSA, and I may not be claimed as a dependant on another person's tax return (excluding spouses per the IRS).
- Avidia Bank is hereby appointed to serve as custodian of my Health Savings Account.
- I have reviewed and agree to the following Agreements and Disclosures; Deposit Account Agreement, Health Savings Custodial, Funds Availability, Electronic Funds Transfer, Check 21. Truth in Savings and Privacy Statement.
- Within seven (7) calendar days from the date I open this HSA, I may revoke authorization for opening the account by mailing a written notice to Avidia Bank, PO BOX 370, Hudson MA 01749.
- To help the government fight the funding of terrorism and money laundering activities, Federal Law requires that all financial institutions obtain, verify and record information that identifies each person who opens an account. What this means to you: when you open an account we will need you and your authorized signer to provide name, street address, date of birth and other information that will allow us to identify you and your authorized signer. We may also ask to see your driver's license or other identifying documents.
- I understand account statements are delivered electronically and I can change delivery preference once enrolled for online access.
- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me).
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.
- I am a U.S. citizen or other U.S. person.

Print Name _____ Signature _____ Date _____