

HSA APPLICATION



Use this HSA Application to open a Health Savings Account.

IMPORTANT: In compliance with the USA PATRIOT Act, Federal law requires all financial institutions (including mutual funds) to obtain, verify, and record information that identifies each person who opens an account.

WHAT THIS MEANS FOR YOU: When you open an account, we will ask for your name, Social Security Number (SSN) or Tax Identification Number (TIN), a physical address (a Post Office box is not acceptable), date of birth, and other information that will allow us to identify you. We may also ask for additional identifying documents. The information is required for all owners, co-owners, or anyone who will be signing or transacting on behalf of a legal entity that will own the account. If any of this information is missing we will not be able to process your investment request. If we are unable to verify this information, your account may be closed and you will be subject to all applicable costs. If you have any questions regarding this application or how to invest, please call Shareholder Services at 1-800-238-7701.

Please note that a \$15.00 annual maintenance/custodian fee will be charged.

PART I: HSA OWNER INFORMATION (*DENOTES REQUIRED INFORMATION)

Name* (First, M.I., Last) Date of Birth* Social Security Number*

Street Address (Physical Address)* Apartment # City* State* Zip Code*

Mailing Address (if different from above) City State Zip Code

Daytime Phone* Evening Phone

U.S. Citizen Resident Alien (Country)
For mailing outside of U.S., provide:

Country of Residence Province Foreign Routing/Postal Code

PART II: EMPLOYER'S INFORMATION (FOR HELP CONSULT YOUR INSURANCE OR EMPLOYER REPRESENTATIVE)

Employer's Name* (First, M.I., Last) Name of Contact* Employer Identification Number*

Mailing Address* Suite # City* State* Zip Code*

Daytime Phone*

PART III: CONTRIBUTION INFORMATION

Source of Funds (Select One)

- Regular Current Year Amount: _____ Carryback* Amount: _____ Tax Year: _____
- Catch-up (age 55+) Current Year Amount: _____ Carryback* Amount: _____ Tax Year: _____
- Transfer Source: HSA MSA Other (Specify) _____
- Rollover Source: HSA MSA Other (Specify) _____
- Other (Specify) _____

* A carryback contribution is made in one tax year and credited for the prior tax year. It must be made by your tax filing due date, excluding extensions. Contributions made to your HSA will be for the current year unless you specify prior year.

Note: The Fund’s initial investment minimum is \$2,000 or \$250 if systematic investment plan of \$100 or more is established.

PART IV: INVESTMENT SELECTION

Name of Investment	Total Investment Amount
1. Archer Balanced Fund	\$

PART V: ACCOUNT SERVICE OPTIONS FOR YOUR HSA

The completion of this section is *OPTIONAL*.

Systematic Investment Program (SIP) – This option provides an automatic investment into your mutual fund(s) by transferring money directly from your bank account via ACH (Automated Clearing House) on a scheduled basis. Automatic investment plan must be established with a \$100 minimum. Please refer to the fund prospectus for other account restrictions. Please provide all of your bank account information AND attach a voided check or deposit slip. **Important: Contributions made to your HSA using SIP will be for the current tax year.** Keep this in mind for investments made from January 1 through April 15.

I authorize Archer Balanced Fund to initiate investments into my mutual fund account according to the following frequency:

- Annually Semi-Annually Quarterly Bi-Weekly Monthly Other (Check months below)
- January February March April May June
- July August September October November December

Fund _____ Amount \$ _____ Day of Month (1st, 15th, etc.) _____

Bank Account Information

Provide information about your checking or savings account to establish a Systematic Investment Program by ACH. Please select one of the following:

- Attach a voided check or deposit slip for your bank account. **Please use tape; do not staple.**
- Provide information about your bank account below.

PART V: ACCOUNT SERVICE OPTIONS FOR YOUR HSA-CONTINUED

Enter your checking or savings account information:

Name: _____

Name of Bank: _____ Bank's Phone Number: _____

Bank Address: _____ ABA Routing Number: _____

City: _____ State: _____ Zip Code: _____

Name(s) on Bank Account: _____ Bank Account Number: _____

Account Type: Checking Savings

John and Jane Doe 123 Any Street Anytown, USA 12345	Date _____	1003
PAY TO THE ORDER OF _____	Tape your voided check or preprinted deposit slip here. Please do <u>not</u> use staples.	\$ _____ DOLLARS
BANK NAME BANK ADDRESS		
MEMO _____		

PART VI: HSA ELIGIBILITY CERTIFICATION

I am eligible to establish an HSA and certify the following. (All must be answered "yes" to be eligible to establish an HSA to receive regular contributions).

1. I am not able to be claimed as a dependent on someone else's tax return. Yes No
2. I am covered under a qualifying High Deductible Health Plan (HDHP), effective _____ Yes No
3. I am not covered under any other insurance plan that is not an HDHP (with limited exceptions). Yes No
4. I am not enrolled in Medicare. Yes No

NOTE: Eligibility is determined on the first day of each month. If you are not an eligible individual for all 12 months of a year, the annual contribution limit may be prorated. For assistance in determining your eligible contribution amount, consult your tax advisor.

PART VII: BENEFICIARY DESIGNATION

Designate beneficiaries below. If the Primary or Contingent status is not indicated, the individual or entity will be considered a Primary beneficiary. After your death, your HSA assets will be distributed in equal shares (unless indicated otherwise) to the Primary beneficiaries who survive you. If no Primary beneficiaries are living when you die, your HSA assets will be distributed in equal shares (unless otherwise indicated) to the Contingent beneficiaries who survive you. You may revoke or change the beneficiary designation at any time by completing a new designation in a form acceptable to the Trustee/Custodian and by providing it to the Trustee/Custodian.

Type: Primary Contingent Share Percentage: _____ % Relationship to IRA Owner: spouse non-spouse
Name: _____ Taxpayer ID Number: _____ Date of Birth: _____
Residence Address: _____

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Name: _____ Taxpayer ID Number: _____ Date of Birth: _____
Residence Address: _____

Addendum attached for additional beneficiaries. If you need additional space to name beneficiaries, attach a separate sheet that includes all of the information requested above. Sign and date the sheet.

To name a trust as your beneficiary, attach to this form either a copy of the trust agreement or a certification, in writing, acceptable to the HSA Custodian.

PART VIII: DUPLICATE ACCOUNT STATEMENT

Yes, please send a duplicate statement to:

Name: _____
Physical Address: _____ City: _____ State: _____ Zip: _____

PART IX: PAYMENT METHOD

You can open your account by either of these methods. Please check your choice:

- By Check** Enclose a check payable to Archer Balanced Fund for the total amount.
- By Wire** For wire instructions call Shareholder Services at 1-800-238-7701.
- Other** _____

(Third party checks, counter checks, starter checks, traveler’s checks, checks drawn on non-U.S. financial institutions, money orders, credit card checks, and cash are not acceptable.) Note: Cashier’s checks and bank official checks may be accepted in amounts greater than \$10,000.

PART X: SPOUSAL CONSENT

Complete this section only if you, the HSA Owner, have your legal residence in a community or marital property state and you wish to name a beneficiary other than or in addition to your spouse as primary beneficiary. This section may have important tax consequences to you and your spouse so please consult with a competent advisor prior to completing. If not currently married and you marry in the future, you must complete a new beneficiary designation that includes the spousal consent provisions.

CONSENT OF SPOUSE

By signing below, I acknowledge that I am the spouse of the HSA Owner and agree with and consent to my spouse's designation of a primary beneficiary other than, or in addition to, me. I have been advised to consult a competent advisor and I assume all responsibility regarding this consent. The Custodian has not provided me any legal or tax advice.

Signature of Spouse

X _____ Date: _____

Witness

X _____ Date: _____

PART XI: AUTHORIZED SIGNER

To permit someone else (such as your spouse) to authorize payments from your HSA, complete the information below and have the authorized person sign the "Acknowledgement" section at bottom.

Name* (First, M.I., Last) Date of Birth* Social Security Number*

Street Address (Physical Address)* Apartment # City* State* Zip Code*

U.S. Citizen Resident Alien (Country)

For mailing outside of U.S., provide:

Country of Residence Province Foreign Routing/Postal Code

PART XII: ACKNOWLEDGEMENT

By signing this *HSA Application*, I certify that the information I have provided is true, correct, and complete, and the Custodian may rely on what I have provided. I have read and received copies of this *HSA Application*, *IRS Form 5305-C*, and *Disclosure Statement* (including the applicable fee schedule). I agree to be bound to their terms and conditions. I understand that the Custodian has no duty or responsibility to determine whether my HDHP complies with the requirements of Section 223 of the Internal Revenue Code nor to determine or validate whether distributions I take from my HSA are used to pay for qualifying medical expenses. I assume all responsibilities for the HSA transactions I conduct, and I will indemnify and hold the Custodian harmless from any consequences related to executing my directions. If I have indicated any amounts as "carryback" contributions, I understand the contributions will be credited for the prior tax year. I have been advised to seek competent legal and tax advice and have not been provided any such advice from the Custodian.

Signature of HSA Owner

X _____ Date: _____

Signature of HSA Trustee/Custodian Representative

X _____ Date: _____

Signature of Authorized Signer:

X _____ Date: _____

PART XIII: FOR DEALER USE ONLY

Financial Institution Name

Representative's Full Name

Address

Representative's Branch Office Telephone Number

City

State

Zip Code

Dealer Number

Branch Number

Representative Number

X

Representative's Signature

X

Supervisor's Signature

PART XIV: MAILING INSTRUCTIONS

Please send completed application to:

Regular Mail Delivery

Archer Balanced Fund
P.O. Box 6110
Indianapolis, IN 46206-6110

Overnight Delivery

Archer Balanced Fund
2960 N. Meridian Street Suite 300
Indianapolis, IN 46208