



HEALTH SAVINGS ACCOUNTS AUTHORIZED SIGNER AGREEMENT

Responsible Individual Name: _____

HSA Member Number: _____

AUTHORIZED USER INFORMATION

Authorized Signer Name: _____ Member Number: _____

Address: _____

Social Security Number: _____ Date of Birth: _____

Day Time Phone: _____ Evening Phone: _____

Driver's license/Other ID#: _____

ID Type: _____ ID Expiration Date: _____

By signing below, I, the Responsible Individual, request that the individual named above be added as an Authorized Signer to the above referenced Health Savings Account (HSA) and agree to be bound by the following conditions:

1. The Authorized Signer must be at least 18 years old.
2. The Authorized Signer will have access to all account information and the same authority to authorize transactions on this account.
3. The only way to terminate an Authorized Signer's access to the account is to notify RCU in writing. To maintain the security of the account, RCU advises that I obtain a new Member number after deleting an Authorized Signer's authority to conduct business on the HSA. Because RCU has no control over the information (such as identifying information) or documents (such as blank checks) the Authorized Signer may have regarding my accounts or me, RCU will not be responsible for transactions by a former Authorized Signer unless I change my Member number.
4. The authorized signer must be a Member with RCU in good standing.
5. The Authorized Signer's authority terminates upon my death.

Responsible Individual Signature Date

Authorized Signer Signature Date