Health Savings Account (HSA) Authorized Signer Add/Delete Form

Instructions: Please complete the fields below and return this form, by mail or fax, to: Spectrum Credit Union, P.O. Box 2069, Oakland, CA 94604-2069, FAX: 415-522-5160. For assistance, please call 510-251-6000 or toll-free 800-782-8782.

Account Owner Information

Member Number/Share ID

First Name | Middle Name | Last Name | Suffix

SECTION A: Add Authorized Signer

Since regulations require that only one individual own a Health Savings Account (HSA), you may want your spouse and/or a third party to be an authorized signer to write checks or use your Debit Card.

I (account owner), as named above, designate the following individual as an additional Authorized Signer on my Health Savings Account.

First Name | Middle Name | Last Name | Suffix

Social Security Number/TIN | Date of Birth | Password

Residential Address (No P.O. Box) | City | State | Postal Code | Country

Home Phone | Cell Phone

Employment Status: ☐ Employed ☐ Homemaker ☐ Retired ☐ Self-employed ☐ Student ☐ Unemployed

Occupation – If retired, previous occupation | Employer Name – If student, school name

Employer/School City, State, and Country

Work Phone (optional) | Email

ID# (e.g. U.S. Driver's License, State or Military ID, or a Passport) | Issuing State/Country | Issue Date | Expiration Date

To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify and record information that identifies each person on an account. What this means to you: When you add an authorized signer to your account we need you to provide your authorized signer's name, street address, date of birth, and other information that will allow us to identify your authorized signer. We may also ask to see your authorized signer's driver's license or other identifying documents. Your authorized signer will be added to your account upon verification of their identity.

Order HSA Debit Card and/or Checks for New Authorized Signer

☐ Yes ☐ No Order a new HSA Debit Card for the Authorized Signer named above.

☐ Yes ☐ No Order new HSA checks for the Authorized Signer named above.

If the Authorized Signer does not receive his/her Debit Card and/or checks within 10 business days, please contact the Credit Union.

Signatures

You hereby designate the above 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 Chevron Federal Credit Union (CFCU) dba Spectrum Credit Union (Spectrum) regarding your HSA; make deposits or withdrawals by any means acceptable to Spectrum, including paper and electronic methods such as ACH and Internet-generated transactions; receive and have access to HSA 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 Spectrum HSA.

You specifically authorize Spectrum, as custodian of your HSA, to rely upon this authorization and designation until such time, if any, that Spectrum 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 Spectrum Account Disclosures which have been provided to you.

You hold harmless and indemnify Spectrum against any claims against or losses Spectrum may suffer arising out of Spectrum’s reliance on this authorization, and release Spectrum from any liability arising from such reliance, unless otherwise proh bited 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 SPECTRUM 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.

HSA Owner Signature _____ Date _____

Authorized Signer Signature (only if adding) _____ Date _____

SECTION B: Delete Authorized Signer

Authorized Signer to be removed from account:

First Name _____ Middle Name _____ Last Name _____ Suffix _____

Date of Birth _____

Note: HSA Debit Card will be deactivated for Authorized Signer.

Signature

The Authorized Signer authority previously granted to the Authorized Signer listed above is hereby terminated. I understand that I am respons ble for recovering any checks or Debit Cards which are in the possession of the Authorized Signer.

HSA Owner Signature _____ Date _____