AvidiaBank

Authorized Signer Form

Instructions: Use this form to update your existing Health Savings Account. Complete this form and mail it to 1550 Liberty Ridge Drive, Suite 330 Wayne, PA 19087 or fax it to 844-791-8315. For assistance, send an email to flex@ebms.com or call 866-857-8182.

Account Holder's Personal Information: All fields required unless otherwise indicated

First Name		MI		Last Name	
Social Security #		Account #		DOB (mm/dd/yyyy)	

Authorized Signer Information: (P.O. Box not accepted)

Since regulations require that only one individual own a Health Savings Account (HSA), the account holder may want his/her spouse and/or third party to be an authorized signer to write checks or use his/her debit card. ***Note: Authorized signers must be 18 years or older.***

I (account holder), as named above, designate the following individual as an additional authorized signer on my Health Savings Account.

Authorized Signer First Name		MI		Authorized Signer Last Name			
Social Security #				DOB (mm/dd/yyyy)			
Driver License #		License State		Issue Date	(mm/dd/yyyy)	Expiration Date	(mm/dd/yyyy)
Street Address		City		State		Zip Code	
Home Phone							

☐ This is the first authorized signer request submitted for my account. Please send a complimentary HSA Card to the individual listed above.

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 will 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.

Signatures:

If you wish to designate an authorized signer on your account, please complete all of the required fields listed above. 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 an d 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 y our 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.*

Owner _____ Date _____

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