



HEALTH SAVINGS ACCOUNT ADOPTION AGREEMENT

ACCOUNT OWNER INFORMATION

Name: _____ Social Security #: _____ Plan #: _____
 Address: _____ Birthdate: _____
 Home Phone: _____ Business Phone: _____ E-Mail Address: _____

DESIGNATION OF HSA PLAN BENEFICIARIES

Primary Contingent Name: _____ Birthdate: _____
 _____ Address: _____
 Social Security Number: _____ Relationship: _____ Share: _____ %

Primary Contingent Name: _____ Birthdate: _____
 _____ Address: _____
 Social Security Number: _____ Relationship: _____ Share: _____ %

_____ See attached HSA Beneficiary Designation Form, dated _____, for information regarding additional plan beneficiaries.

In the event of my death, the balance in the plan shall be paid to the Primary Beneficiaries who survive me in the specified shares (or in equal shares, if not otherwise indicated). If the Primary or Contingent Beneficiary line is not checked for a beneficiary, the beneficiary will be deemed to be a Primary Beneficiary. If none of the Primary Beneficiaries survive me, the balance in the plan shall be paid to the Contingent Beneficiaries who survive me in the specified shares (or in equal shares if not otherwise indicated).

EMPLOYER & HEALTH INSURANCE INFORMATION

Name of Employer: _____
 Health Insurance Provider: _____
 Coverage Effective Date: _____ Coverage for: _____ Individual _____ Family

HSA PLAN TRUSTEE INFORMATION

Trustee: First Niagara Bank, 6950 South Transit Rd, Lockport NY 14094
 Customer Service Contact Information: 1-800-421-0004 or at www.fnfg.com
 Revocation Information: To revoke this HSA a notice of revocation must be delivered or mailed to:
 Judy L. Balkin, First Niagara Bank, 55 East Avenue, P.O. Box 886, Lockport NY 14095-0886
 Telephone: 716-625-7569

ACCOUNT INFORMATION

_____ Regular HSA Contribution for Tax Year: _____ Contributions to be made by:
 _____ Trustee to Trustee Transfer from Another HSA _____ HSA Account Holder and/or Family Member
 _____ Rollover from another HSA or Archer MSA _____ Employer
 _____ Surviving Spouse Assumption

HEALTH SAVINGS ACCOUNT ADOPTION AGREEMENT

ACCOUNT OWNER NAME: _____

SOCIAL SECURITY NUMBER: _____

HSA ACCOUNT OPTIONS

_____ I would like to receive a free First Niagara HSA Debit MasterCard issued in my name to access my HSA account for normal distributions only.

_____ I would like to receive a free order of non-duplicate HSA checks to be used for normal distributions only.

_____ I would like to receive a free order of pre-printed deposit coupons for my HSA account to facilitate employee contributions to the plan.

NOTE: Purchases or payments made with either the First Niagara HSA Debit MasterCard or First Niagara HSA checks or in-branch withdrawals will be reported by the Bank as "normal distributions" unless an HSA Distribution Request indicating otherwise is completed. All in-branch contributions will be reported by the Bank as an employee contribution for the current tax year, unless an HSA contribution form or pre-printed HSA deposit ticket indicating otherwise is completed for the transaction. I understand I should not use my HSA Debit MasterCard or HSA checks for non-qualifying or non-medical purposes and that I am responsible for any IRS penalties.

To authorize a spouse or third party to access to your HSA, please complete the Authorized Signer/Power of Attorney section below.

HSA AUTHORIZED SIGNER/POWER OF ATTORNEY (POA) DESIGNATION

As the HSA Account Owner, I designate the following individual* as an additional signer on my First Niagara Bank Health Savings Account.

Name of Authorized Signer/Power of Attorney (POA): _____ Birth Date of POA: _____

Social Security # of POA: _____ Relationship to HSA Account Owner: _____

_____ Please issue a second free First Niagara HSA Debit MasterCard in the name of the Authorized Signer/Power of Attorney (POA) designated above, attached to my HSA account to be used for normal distributions only.

_____ Please honor checks issued on my HSA account, signed by the Authorized Signer/Power of Attorney designated above to facilitate access to my HSA for normal distributions only.

BOTH THE HSA ACCOUNT OWNER AND THE AUTHORIZED SIGNER/POA DESIGNATED ABOVE MUST SIGN BELOW FOR THIS DESIGNATION TO BE EFFECTIVE.

*** HSA Authorized Signer/Power of Attorney must be at least age 18**

SIGNATURES

Under penalties of perjury, I certify that the above information including my social security number is correct. I hereby agree to participate in the Health Savings Account offered by the Trustee. I acknowledge receipt of a copy of the plan document under which this Health Savings Account is established, a copy of this Adoption Agreement, a copy of the Disclosure Statement and the Bank's HSA Plan Distribution Policy with respect to this Health Savings Account. I direct that my contribution be invested as indicated above and that all benefits upon my death be paid as indicated above. I authorize the Trustee to deduct any fees and/or other charges that may apply now or in the future from my HSA in accordance with Article 7.05. I acknowledge that I am responsible for determining my eligibility to participate in this HSA, the amount of deductibility of contributions hereunder, the taxation of any distributions from this HSA, and that no tax advice has been provided by the Trustee. I certify that I am an Eligible Individual and that my health plan qualifies as a High Deductible Health Plan.

In the event that this is a rollover contribution, the undersigned hereby irrevocably elects to treat this contribution as a rollover contribution. I certify that the following are true and correct:

1. This rollover contribution is being made within 60 days after my receipt of the funds from another HSA or an Archer MSA, in which I was either the participant or the surviving spouse beneficiary; **and**
2. During the 12-month period prior to my receipt of the distribution being rolled over, I have not received a distribution from the same HSA which was subsequently rolled over to another HSA, and the distribution being rolled over has not been part of a distribution from another HSA that was subsequently rolled over.

I understand that the rollover contributions are reported to the IRS. I hereby release The Bank from any claim for damages due to the failure of this transaction to qualify as a valid rollover.

Participant's Signature: _____ Date: _____

HSA Authorized Signer/Power of Attorney Signature: _____ Date: _____

Bank Representative's Signature: _____ Date: _____

BANK USE ONLY

Account #: _____ Deposit Amount: \$ _____ Offset: _____

Teller Tran. Code: _____ Account Type: _____ Ret. Cont. Code: _____ Teller: _____