Health Savings Account (HSA) Enrollment Form for Individuals

Please mail completed form to:
Wells Fargo Health Benefit Services, NW 5613, P.O. Box 1450, Minneapolis, MN 55485-5613

Contact Information

Last Name	First Name	M.I.	Date of Birth	Social Security #

Street Address	City	State	Zip

E-Mail Address	Home Phone # (area code)	Work Phone # (area code & ext.)

Plan Name	My HSA Contribution Limit	Coverage Effective Date
Cargill		

Broker	Broker ID	Group ID No. (if required)
N/A	N/A	

Tax Year	HDHP Deductible	Coverage for
Note: All initial funds will be deposited in the tax year in which they are received unless indicated otherwise.		☐ Individual ☐ Family (includes Employee + 1, Employee + Spouse, and Employee + Children, Family)

Account Setup

Minimum Opening Deposit: $ 100.00

Additional Opening Deposit: + __________________

Total Deposit Enclosed: $

(Include a check or money order payable to Wells Fargo Health Benefit Services.)

Administrative Fees: A monthly administrative fee will automatically be deducted from your HSA on the first day of each month. The amount of this administrative fee is $«fee»/month, unless otherwise stated in your plan information.

Note on Investment Fund Elections: The first $100 I contribute will be deposited to a non-interest-bearing cash fund. Thereafter, my contributions will be invested in the Wells Fargo Advantage Cash Investment Money Market Service Fund until I select other available funds. Once my account is activated, I may select these funds online or by calling my HSA customer service number. I understand that I will receive a prospectus for the funds in which my HSA balances are invested immediately following a deposit into a fund. I understand that investments in any such fund are not obligations of, or endorsed or guaranteed by, Wells Fargo Bank or its affiliates and are not insured by the Federal Deposit Insurance Corporation. I acknowledge that I have full power to direct investments of the accounts. I understand that I may change this direction at any time and that it shall continue in effect until revoked or modified by me. Wells Fargo Funds Management, LLC serves as investment advisor and Wells Fargo Bank, N.A., serves as custodian for the Wells Fargo Advantage Funds. I also understand that Wells Fargo Bank, N.A. will be paid, and certain of its affiliates may be paid, fees for services to the Wells Fargo Advantage Funds and that those fees are described in the prospectus.

Please open a health savings account (HSA) in my name. I certify that I am eligible to contribute to an HSA according to federal regulations and tax code §223, and my annual contribution will not exceed the amount permitted for my situation.

I hereby request that *Wells Fargo Health Benefit Services* establish a health savings account (HSA) in my name. I acknowledge that this account will be established according to the *Health Savings Account Disclosure and Trust Account Agreement for Employees and Individuals*. I certify that account deposits will be contributed according to the *Account Setup* detailed above. I also certify that *Wells Fargo Health Benefit Services* is authorized to act in accordance with any future documents bearing my signature. I understand that I may revoke this agreement within seven days in accordance with the terms of the *Health Savings Account Disclosure and Trust Account Agreement for Employees and Individuals*.

By signing this enrollment form, I authorize Wells Fargo Health Benefit Services to disclose account information to my spouse for recordkeeping purposes. This direction applies to all accounts under my name for which Wells Fargo Health Benefit Services acts as the administrator, including, but not limited to health savings accounts, flexible spending accounts and health reimbursement arrangements. Account information that may be shared may include account balance, investment elections (if offered), reimbursements made or claims processed, deposits and withdrawals. This authorization will remain in place until I revoke it in writing.* Wells Fargo Health Benefit Services does not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. If I object to this disclosure or wish to revoke it, I may contact Wells Fargo Health Benefit Services. If the information Wells Fargo Health Benefits Services provides to my spouse is made public by my spouse, that disclosure is no longer protected by HIPAA.

The USA PATRIOT ACT OF 2001 requires financial institutions to obtain, verify and record information to confirm the identity of each individual or entity that opens an account. What this means for you: before you open an account, we will ask for your name, address, date of birth (if you are an individual), taxpayer identification number (TIN), and other information that will allow us to identify you. For entities opening new accounts, we will ask you for documentation that may include annual reports, government issued business licenses or partnership agreements.

☐ I certify that the purpose and funds for this account are for a Health Savings Account (HSA).

If no, please explain:

What is the source of the funds maintained in the account:	How were you referred to Wells Fargo:
☐ Employer Funds ☐ Personal Funds ☐ Rollover or transfer ☐ Other (please explain):	

Primary Beneficiary Information

Name	Relationship	Social Security #

Address	City	State	Zip

The rights of the beneficiary named above shall be subject to all terms and conditions of the *Health Savings Account Disclosure and Trust Account Agreement for Employees and Individuals* (the "Plan Document") and shall be effective only if received by Wells Fargo Health Benefit Services prior to the death of the account holder. This designation applies to all of the HSA funds that remain undistributed from this account at the account holder's death. If the account holder wishes to name additional primary beneficiaries or contingent beneficiaries, he or she may obtain a form by calling his or her HSA customer service number. If no primary beneficiary survives the account holder, payment of funds shall be made to surviving contingent beneficiaries or if none, in accordance with the terms of the Plan Document. This designation may be changed at any time by filing a written change with Wells Fargo Health Benefit Services.

Signature of Account Holder	Date of Application

Web site: www.wfhbs.com/cargill
Phone: 866-890-8309

Wells Fargo Health Benefit Services is a division of Wells Fargo Bank N.A. and provides administrative services to the Health Savings Accounts on behalf of Wells Fargo Bank N.A. as trustee.
*Health Benefit Services Change Forms (and other forms) are available online at the Web site listed above.

CONFIDENTIAL ONCE COMPLETED AND RETURNED