

**Health Savings Account Application**

HSA Owner Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_

Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_

Phone \_\_\_\_\_

Employer \_\_\_\_\_

Chexsystems Authorization: X \_\_\_\_\_  
*by signing above you authorize Logansport Savings Bank to verify  
your banking history through third party verifier Chexsystems*

**Authorized Signer** (i.e. spouse, qualified dependent)  
SIGNER #1:

Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_

Phone \_\_\_\_\_

Chexsystems Authorization: X \_\_\_\_\_  
*by signing above you authorize Logansport Savings Bank to verify  
your banking history through third party verifier Chexsystems*

Relationship to owner \_\_\_\_\_

**Authorized Signer** (i.e. spouse, qualified dependent)  
SIGNER #2:

Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_

Phone \_\_\_\_\_

Chexsystems Authorization: X \_\_\_\_\_  
*by signing above you authorize Logansport Savings Bank to verify  
your banking history through third party verifier Chexsystems*

Relationship to owner \_\_\_\_\_

**Plan Coverage**

HEALTH INSURANCE PLAN \_\_\_\_\_ Self-Only Coverage \_\_\_\_\_ Family Coverage

**Beneficiary Information**

*Primary Beneficiary-*

Percentage      Name                      Social Security #              Date of Birth              Relationship

\_\_\_\_\_ % \_\_\_\_\_

\_\_\_\_\_ % \_\_\_\_\_

\_\_\_\_\_ % \_\_\_\_\_

\_\_\_\_\_ % \_\_\_\_\_

**100%**

*Contingent Beneficiary-*

Percentage      Name                      Social Security #              Date of Birth              Relationship

\_\_\_\_\_ % \_\_\_\_\_

\_\_\_\_\_ % \_\_\_\_\_

\_\_\_\_\_ % \_\_\_\_\_

\_\_\_\_\_ % \_\_\_\_\_

**100%**

Please, supply a legible **photo-copy of Indiana Driver's License or Indiana Identification and a 2nd form of ID** (i.e. Social Security card, Major Credit Card, Birth Certificate) **for owner/participant and all signers**

\*Please initial here \_\_\_\_\_ if you would like a Debit Card(s) with this account in addition to checks.

X \_\_\_\_\_

**HSA Owner Signature**

DEBIT CARD APPLICATION /MAINTENANCE

LAST NAME	FIRST NAME	MIDDLE INITIAL
STREET ADDRESS	APT NUMBER	PO BOX
CITY	STATE	ZIP CODE
( )	DAY TIME PHONE NUMBER	SOCIAL SECURITY NUMBER

CONFIRM ADDRESS ON FILE

EXISTING CARD NUMBER \_\_\_\_\_

ISSUE NEW CARD & PIN - New Number \_\_\_\_\_

\*HOT CARD -CARD LOST/STOLEN Int. \_\_\_\_\_

CLOSE CARD - REASON FOR CLOSING \_\_\_\_\_

PIN REORDER

RE-ISSUE CARD SAME NUMBER

\*INCREASE LIMIT TO \$ \_\_\_\_\_ DATES \_\_\_\_\_ ATM or POS Int. \_\_\_\_\_

INCREASE # OF TRANSACTIONS TO \_\_\_\_\_

\*ACTIVATE CARD - OSI \_\_\_\_\_ Int.  CLIENT CENTRAL \_\_\_\_\_

FRAUD ON CARD (If yes, fill out back side and have customer re-sign)

TRAVEL RESTRICTIONS – Country or Area – beginning \_\_\_\_\_ ending \_\_\_\_\_

Account Number(s) to LINK \_\_\_\_\_

Type of account \_\_\_\_\_

Check Notes _____	Processing Date and Initials _____
Disclosure Given _____	CSR Date and Initials _____
FEE CHARGED _____	

\_\_\_\_\_  
CUSTOMER'S SIGNATURE DATE

**MASTERCARD FRAUD REPORTING FORM**

I, \_\_\_\_\_, state that on \_\_\_\_\_ a debit entry from my MasterCard Debit Card # \_\_\_\_\_ was charged to Account # \_\_\_\_\_ in the amount of \$ \_\_\_\_\_ for the benefit of \_\_\_\_\_,

and that the debit was unauthorized and not performed by me.

\_\_\_\_\_ My card is and has been in my possession.

\_\_\_\_\_ My card is lost/or has been stolen. I reported this on \_\_\_\_\_.

\_\_\_\_\_ The amount that I authorized to this Merchant was \$ \_\_\_\_\_ I am requesting a refund of \$ \_\_\_\_\_ which is the difference between what they were authorized to charge my account and what they actually debited my account for.

\_\_\_\_\_ I have not been able to contact the merchant because \_\_\_\_\_

\_\_\_\_\_ I have contacted the merchant and was told the following \_\_\_\_\_

\_\_\_\_\_ In addition the transactions below were also unauthorized.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

Printed \_\_\_\_\_

Address \_\_\_\_\_

Best Contact Phone # \_\_\_\_\_