



Use this HSA Application to open a Health Savings Account.

IMPORTANT: In compliance with the USA PATRIOT Act, Federal law requires all financial institutions (including mutual funds) to obtain, verify, and record information that identifies each person who opens an account.

WHAT THIS MEANS FOR YOU: When you open an account, we will ask for your name, Social Security Number (SSN) or Tax Identification Number (TIN), a physical address (a Post Office box is not acceptable), date of birth, and other information that will allow us to identify you. We may also ask for additional identifying documents. The information is required for all owners, co-owners, or anyone who will be signing or transacting on behalf of a legal entity that will own the account. If any of this information is missing we will not be able to process your investment request. If we are unable to verify this information, your account may be closed and you will be subject to all applicable costs. If you have any questions regarding this application or how to invest, please call Shareholder Services at 1-877-832-6952.

Please note that a \$15.00 annual maintenance/custodian fee will be charged.

PART I: HSA OWNER INFORMATION (*DENOTES REQUIRED INFORMATION)

Name* (First, M.I., Last) _____ Date of Birth* _____ Social Security Number* _____

Street Address (Physical Address)* _____ Apartment # _____ City* _____ State* _____ Zip Code* _____

Mailing Address (if different from above) _____ City _____ State _____ Zip Code _____

Daytime Phone* _____ Evening Phone _____

U.S. Citizen Resident Alien (Country)
For mailing outside of U.S., provide:

Country of Residence _____ Province _____ Foreign Routing/Postal Code _____

PART II: EMPLOYER'S INFORMATION (FOR HELP CONSULT YOUR INSURANCE OR EMPLOYER REPRESENTATIVE)

Employer's Name* (First, M.I., Last) _____ Name of Contact* _____ Employer Identification Number* _____

Mailing Address* _____ Suite # _____ City* _____ State* _____ Zip Code* _____

Daytime Phone* _____

PART III: CONTRIBUTION INFORMATION

Source of Funds (Select One)

- Regular Current Year Amount: _____ Carryback* Amount: _____ Tax Year: _____
- Catch-up (age 55+) Current Year Amount: _____ Carryback* Amount: _____ Tax Year: _____
- Transfer Source: HSA MSA Other (Specify) _____
- Rollover Source: HSA MSA Other (Specify) _____
- Other (Specify) _____

* A carryback contribution is made in one tax year and credited for the prior tax year. It must be made by your tax filing due date, excluding extensions. Contributions made to your HSA will be for the current year unless you specify prior year.

Note: The Fund’s initial investment minimum is \$1,000. Please refer to the prospectus for additional information on the Fund minimums.

PART IV: INVESTMENT SELECTION

Name of Investment	Total Investment Amount
1. TEAM Asset Strategy Fund	\$

PART V: ACCOUNT SERVICE OPTIONS FOR YOUR HSA

The completion of this section is *OPTIONAL*.

Systematic Investment Program (SIP) – This option provides an automatic investment into your mutual fund(s) by transferring money directly from your bank account via ACH (Automated Clearing House) on a scheduled basis. Automatic investment plan must be established with a \$100 minimum. Please refer to the fund prospectus for other account restrictions. Please provide all of your bank account information AND attach a voided check or deposit slip. **Important: Contributions made to your HSA using SIP will be for the current tax year.** Keep this in mind for investments made from January 1 through April 15.

I authorize TEAM Asset Strategy Fund to initiate investments into my mutual fund account according to the following frequency:

- Annually Semi-Annually Quarterly Twice Each Month Monthly Other (Check months below)
- January February March April May June
- July August September October November December

Fund _____ Amount \$ _____ Day of Month (1st, 15th, etc.) _____

Bank Account Information

Provide information about your checking or savings account to establish a Systematic Investment Program by ACH. Please select one of the following:

- Attach a voided check or deposit slip for your bank account. **Please use tape; do not staple.**
- Provide information about your bank account below.

PART V: ACCOUNT SERVICE OPTIONS FOR YOUR HSA-CONTINUED

Enter your checking or savings account information:

Name: _____

Name of Bank: _____ Bank's Phone Number: _____

Bank Address: _____ ABA Routing Number: _____

City: _____ State: _____ Zip Code: _____

Name(s) on Bank Account: _____ Bank Account Number: _____

Account Type: Checking Savings

John and Jane Doe 123 Any Street Anytown, USA 12345	Date _____	1003
PAY TO THE ORDER OF _____	Tape your voided check or preprinted deposit slip here. Please do <u>not</u> use staples.	\$ _____ DOLLARS
BANK NAME BANK ADDRESS		
MEMO _____		

PART VI: HSA ELIGIBILITY CERTIFICATION

I am eligible to establish an HSA and certify the following. (All must be answered "yes" to be eligible to establish an HSA to receive regular contributions).

- 1. I am not able to be claimed as a dependent on someone else's tax return. Yes No
- 2. I am covered under a qualifying High Deductible Health Plan (HDHP), effective _____ Yes No
- 3. I am not covered under any other insurance plan that is not an HDHP (with limited exceptions). Yes No
- 4. I am not enrolled in Medicare. Yes No

NOTE: Eligibility is determined on the first day of each month. If you are not an eligible individual for all 12 months of a year, the annual contribution limit may be prorated. For assistance in determining your eligible contribution amount, consult your tax advisor.

PART VII: BENEFICIARY DESIGNATION

Designate beneficiaries below. If the Primary or Contingent status is not indicated, the individual or entity will be considered a Primary beneficiary. After your death, your HSA assets will be distributed in equal shares (unless indicated otherwise) to the Primary beneficiaries who survive you. If no Primary beneficiaries are living when you die, your HSA assets will be distributed in equal shares (unless otherwise indicated) to the Contingent beneficiaries who survive you. You may revoke or change the beneficiary designation at any time by completing a new designation in a form acceptable to the Trustee/Custodian and by providing it to the Trustee/Custodian.

Type: Primary Contingent Share Percentage: _____% Relationship to IRA Owner: spouse non-spouse
Name: _____ Taxpayer ID Number: _____ Date of Birth: _____
Residence Address: _____

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Name: _____ Taxpayer ID Number: _____ Date of Birth: _____
Residence Address: _____

Addendum attached for additional beneficiaries. If you need additional space to name beneficiaries, attach a separate sheet that includes all of the information requested above. Sign and date the sheet.

To name a trust as your beneficiary, attach to this form either a copy of the trust agreement or a certification, in writing, acceptable to the HSA Custodian.

PART VIII: DUPLICATE ACCOUNT STATEMENT

Yes, please send a duplicate statement to:
Name: _____
Physical Address: _____ City: _____ State: _____ Zip: _____

PART IX: PAYMENT METHOD

You can open your account by either of these methods. Please check your choice:

- By Check** Enclose a check payable to TEAM Asset Strategy Fund for the total amount.
- By Wire** For wire instructions call Shareholder Services at 1-877-832-6952.
- Other** _____

(Third party checks, counter checks, starter checks, money orders, traveler’s checks, checks drawn on non-U.S. financial institutions, credit card checks, and cash are not acceptable.) Note: Cashier’s checks and bank official checks may be accepted in amounts greater than \$10,000.

PART XIII: FOR DEALER USE ONLY

Financial Institution Name

Representative's Full Name

Address

Representative's Branch Office Telephone Number

City

State

Zip Code

Dealer Number

Branch Number

Representative Number

X

Representative's Signature

X

Supervisor's Signature

PART XIV: MAILING INSTRUCTIONS

Please send completed application to:

Regular Mail Delivery
TEAM Asset Strategy Fund
P.O. Box 6110
Indianapolis, IN 46206-6110

Overnight Delivery
TEAM Asset Strategy Fund
2960 N. Meridian Street Suite 300
Indianapolis, IN 46208