ASC TRUST

Plan Year: 2024-2025

Individual Health Savings Account Enrollment Form

Company / Employer Name: _____ Employee ID Number: _____

Employee Name: _____ Soc. Sec. #: _____ - _____ - _____

Mailing Address: _____

Email Address(es): _____

Date of Birth: _____ /_____ /_____ Date of Hire: _____ /_____ /_____ Work #: _____ Home #: _____ Other #: _____

ELIGIBILITY: Do any of the following apply to you?

1. Are you currently covered by a Flexible Spending Account or another Health Insurance Plan (including Tricare or VA coverage)? ☐ Yes ☐ No
2. Are you Eligible for Medicare? ☐ Yes ☐ No
3. Can you be claimed as a tax dependant by another taxpayer? ☐ Yes ☐ No

* ***If you answered "Yes" to any of these questions, you may not be eligible to participate in the HSA. Please contact ASC at (671) 477-2724 for more information.***
* *If* NO – Please continue with the application.

CONTRIBUTION ELECTION

For ASC Use. Effective PPE:

1. HEALTH INSURANCE COVERAGE

☐ I am enrolled in the following High Deductible Health Plan (HDHP): _____

2. TYPE OF INSURANCE COVERAGE - I have the following type of insurance coverage:

☐ **Self-Only Coverage Contribution Limits:** Up to $4,150 for 2024 and up to $4,300 for 2025 (*additional $1,000 if over age 55 for both years)*

☐ **Family Coverage Contribution Limits:** Up to $8,300 for 2024 and up to $8,550 for 2025 (*additional $1,000 if over age 55 for both years)*

3. CONTRIBUTION ELECTION

☐ I am eligible for the Cafeteria Plan and hereby authorize my Employer to withhold the following dollar amount from my compensation **after taxes** and deposit such amount into my HSA at ASC Trust: **$ _____ per pay period**.

☐ I wish to make a contribution on my own (by check payable to: ASC Trust, LLC).

☐ I wish to allow ASC to automatically deduct my contributions from my bank account (must complete ACH Debit Authorization Form).

☐ I do not wish to participate at this time.

INVESTMENT SELECTION: *I hereby authorize ASC to invest my future contributions in the Option selected below. Please contact ASC for more information on the investments.*

OPTION A ☐ **MUTUAL FUNDS**. *Allocate 100% of my contributions into the Profile indicated (choose only one):* ☐ **Conservative Profile** ☐ **Moderate Profile** ☐ **Aggressive Profile**

OPTION B ☐ **STABLE FUND**. *Allocate 100% of my contributions in the Stable Fund.*

OPTION C ☐ **HSA DEBIT CARD (minimum $25 to open)**. *Allocate 100% of my contributions in the HSA Debit Card. (I understand that additional fees may apply.* ***A separate application packet must be completed*** *and you will be provided with full disclosure and additional information.)*

For ASC use only: ☐ VISA application received by ASC Trust ☐ VISA application submitted to BP, Account # _____

OPTION D ☐ **COMBINATION.** *Allocate my contribution as follows.*

_____% to go to the HSA Debit Card ***(A separate application packet must be completed.)***

_____% to go to the Stable Fund

_____% to go to one of the following Profiles: ☐ **Conservative Profile** ☐ **Moderate Profile** ☐ **Aggressive Profile**

FEES

- Health Savings Account Administration Fee : $12.50 per quarter (deducted from HSA account)
- Asset Management Fee : 0.25% per quarter (applies only to Profiles and Stable Fund)

AUTHORIZATION: *I agree to the elections above and acknowledge that I had the opportunity to review the Summary Plan Description for the Cafeteria Plan as it applies to me and the information regarding the investment options above.*

PARTICIPANT SIGNATURE: _____ **DATE:** ____ /____ /_____

PLAN ADMINISTRATOR SIGNATURE: _____ **DATE:** ____ /____ /_____

Health Savings Account Enrollment Form

Company / Employer Name: _____

Employee Name: _____ Soc. Sec. #: _____ - _____ - _____

BENEFICIARY DESIGNATION

As a participant in my company sponsored Health Savings Account, I hereby designate the following beneficiary(ies) to receive such benefit in the order of priority as indicated below. I understand that I may change my beneficiary(ies) at any time. Additionally, because this designation may be invalidated due to a change in my marital status, I understand that I should complete a new Beneficiary Designation Form in the event of such change.

PRIMARY BENEFICIARY *If you are legally married, you must name your spouse as the sole Primary Beneficiary, unless your spouse completes the *Spousal Consent To Waiver As Primary Beneficiary below.* **Marital Status:** ☐ **Married*** ☐ **Not Married**

	Full Name	Birth Date	Social Security #	Relationship to Employee	Share % *(must add up to 100%)*
1.					
2.					
3.					

SECONDARY (CONTINGENT) BENEFICIARY

	Full Name	Birth Date	Social Security #	Relationship to Employee	Share % *(must add up to 100%)*
1.					
2.					
3.					

SPOUSAL CONSENT TO WAIVER AS PRIMARY BENEFICIARY

If you and your spouse agree to name someone other than your spouse as the Primary Beneficiary, your spouse must complete this section.

Spouse Name: _____ Social Security #: _____

I hereby acknowledge that I am the spouse of the participant identified above, and I hereby consent to the payment of my spouse's death benefit to the beneficiary determined on the Beneficiary Designation Form and consent to the payment of such benefit according to any method of payment the beneficiary elects under the Plan. Any change in a designated beneficiary will require my consent. I understand that: (1) as a result of this consent, I am forgoing benefits I would be entitled to receive upon my spouse's death prior to retirement; (2) I do not have to consent to my spouse's waiver of the payment of his/her death benefit to me, and my spouse's waiver is not valid without my consent; (3) I have the right to limit this consent to a specific form of benefit payment to the beneficiary, but I am voluntarily relinquishing this right; and (4) this consent is irrevocable. I hereby make this consent freely and without any duress or undue influence by any party. I understand that I have the right to seek independent advice and counsel with respect to this consent.

Spouse's Signature: _____ Date: _____/_____/_____

NOTARY PUBLIC ACKNOWLEDGMENT

In and for Guam, U.S.A.)
) SS
City of _____)

On this _____ day of _____, 20_____, before me, a Notary Public in and for Guam, personally appeared _____, known to me to be the person whose name is signed on the *Spousal Consent To Waiver As Primary Beneficiary Form*, and acknowledged to me that (he) (she) signed it voluntarily for its stated purpose. IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal the day and year first above written.

_____
Notary Public

PARTICIPANT SIGNATURE: _____ **DATE:** ____/____/_____

PLAN ADMINISTRATOR SIGNATURE: _____ **DATE:** ____/____/_____