www.IdahoMSA.com
800-914-3248

Idaho MSA Application

This is not your Medical Insurance Policy; contact your insurance carrier (or agent) to make changes to your insurance.

IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING A NEW ACCOUNT:
To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions 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, address, date of birth, and other information that will allow Idaho Independent Bank to identify you. We may also ask to see your driver's license or other identifying documents.

ACCOUNT HOLDER INFORMATION: (Please print clearly)

Legal Name_______________________________ Social Security #______________________ Date of Birth___________________

Email Address (Required) ____ Mother's Maiden Name________________________

Mailing Address ____

City____ State__________________ Zip______________

Home Phone (_______) _______________ Cell Phone (_______) _________________ Work Phone (_______) _______________

Residential Address (If different) ____

City____ State__________________ Zip______________

Driver's License #_________________________ State of Issue________ Issue Date____________ Exp. Date______________

JOINT ACCOUNT OWNER:
Adding a joint account owner is optional, however this person must be your spouse and a joint Idaho tax return must be filed.

Legal Name__________________________________ Social Security #__________________ Date of Birth___________________

Mother's Maiden Name________________________ Cell Phone (_______) _________________

Driver's License #_________________________ State of Issue________ Issue Date____________ Exp. Date______________

INSURANCE AGENT INFORMATION:

Agent Name__________________________________ Agent ID (Optional)____

INSURANCE PLAN INFORMATION: (Optional)

Insurance Carrier______________________________ Effective Date of Policy________________ Deductible $________________

Insurance Coverage (Check One) ____Single Insurance Coverage ____Dependent Insurance Coverage

EMPLOYER INFORMATION:

Div #: ______________ Name of Employer____

PAYMENT ENCLOSED WITH APPLICATION:

Opening Deposit (minimum $50.00)………………………… $____________________________________

Annual Fee ($36.00)…………………………………………..$____________________________________

TOTAL ENCLOSED AMOUNT…………………………….....$____________________________________

For Office Use Only

Open Date____________ Acct #_____________ Billing Month: ________________

Grp/Div # ________________ BenCalc ___________ Ck #_______________ Paid Through Date_____/______/_______

BENEFICIARY INFORMATION:

In the event of my death, I name as my beneficiary:

Name ____

Relationship____

ADDITIONAL ACCOUNTS:

Do you currently have a health savings account? ___Yes ___No

What is your current tax filing status in Idaho? ___Single ___Joint

ACCEPTANCE OF TERMS:

By signing below, I acknowledge that annual fees are non-refundable and I apply to Idaho Independent Bank ("Bank" or "IIB") to establish a Medical Savings Account ("Account"). Upon the Bank accepting my application and opening the Account, I authorize the Bank to provide American Health Value all data requested by American Health Value regarding the Account and any related information to the Account, including but not limited to contact information and transactions. American Health Value shall utilize such information to act as the benefit administrator of the account. I understand that I may terminate the sharing of my customer bank information at any time, but I must provide written instructions revoking this authorization to the Bank and provide the Bank a reasonable period of time to act upon my revocation. I understand that I have a separate contract with the Bank for banking services, of which American Health Value is not a party and I have a separate contract with American Health Value regarding benefit administration services, of which the Bank is not a party.

I understand the American Health Value administrative fee will automatically be deducted from my Medical Savings Account on an annual basis.

The account holder is responsible for the establishment and maintenance of this account pursuant to state guidelines. American Health Value is here to assist the account holder in accomplishing this.

MEDICAL SAVINGS ACCOUNT TRUST AGREEMENT:

The custodian and benefit administrator is authorized to act without further inquiry in accordance with writings bearing my signature. I understand that I may revoke the agreement by written notice to the custodian or administrator within seven (7) days after the date of the agreement as specified below.

This deposit account is subject to all rules and regulations applicable to Idaho Independent Bank, as well as all agreements entered into with the Bank including but not limited to the account agreement. I understand the following: the Bank may order a consumer report from a credit reporting agency in order to evaluate my eligibility to open an account; I will be provided the account agreement, signature card and all applicable regulatory disclosures by the Bank upon its receipt and approval of my application to establish a Medical Savings Account; and, my account will not be opened until the signed signature card is returned to the Bank and IIB's account opening requirements have been met. IIB reserves the right to refuse to open and terminate an account for any reason.

I authorize my Benefit Administrator, American Health Value, and/or the Bank to make credit and debit entries to my Checking Account/MSA (Account), where the Bank is the custodian thereof, for the sole purpose of correcting any contributions that may be made in error to my Account. For purposes of this Authorization, Bank may also be referred to as the Depository.

Primary Applicant – Signature Required	Date	Joint Account Owner – Signature Required	Date

MAIL COMPLETED APPLICATION TO: American Health Value, P.O. Box 8063, Boise, ID 83707