



COMMERCIAL BANK

To enroll, please print out the HSA Website Enrollment Packet.

Fill out appropriate areas and mail to:

Commercial Bank
PO Box 423
Mt. Pleasant, MI 48804-0423

If you have any questions and/or concerns, please do not hesitate to contact Commercial Bank at (989) 775-0355.

IMPORTANT NOTICE

• ACCOUNT OVERDRAFTS •

Health Savings Accounts **do not** have an overdraft limit. You must have money in your account to use it. **Overdrawing your account violates IRS rules and could create problems for you. Overdrawing your HSA is a serious matter.**

In the event of overdrawn accounts, the items will be returned unpaid. Any overdrafts caused by the use of your Visa check card will cause immediate termination of your card. We reserve the right to close overdrawn accounts without notice.

Health Savings Account Signature Card

COMMERCIAL BANK

THE INFORMATION BELOW CAN BE USED TO CONFIRM YOUR IDENTITY IF YOU TELEPHONE US OR IN OTHER CIRCUMSTANCES.

****YOU MUST INCLUDE AN ENLARGED COPY OF YOUR DRIVER'S LICENSE OR MICHIGAN STATE ID (FRONT AND BACK)****

Are you a United States Citizen?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Are you, any of your relatives or close contact(s) affiliated with any other government other than the United States? (i.e. affiliated with a senior foreign political figure)	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Name:		DOB:		SSN:	
ID TYPE & NUMBER				Expiration Date:	
Street Address:					
City/State/Zip:					
Mailing Address:					
City/State/Zip:					
Home Phone:		Work Phone:		Cell Phone:	
Mother's Maiden Name:			Birthplace:		
Employer:			Employer Contact:		
Employer Address:					
City/State/Zip:					

TIN/BACKUP WITHHOLDING CERTIFICATION

Important: Under penalties of perjury, I certify that the number shown above is my correct taxpayer identification number and that (check appropriate box):

- I am not subject to backup withholding, because I am exempt from backup withholding, or because I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding.
- I am subject to backup withholding.

I am a U.S. person (including a U.S. resident alien).

X

Signature of Account Holder	Date
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ELIGIBILITY REQUIREMENT: Account holder certification: I certify that: (1) I am covered by a Qualified High Deductible Health Plan (QHDHP), and (2) I certify that I am not covered by a health plan, other than a QHDHP, which provides any of the same benefits as the QHDHP. Participants in a Health Savings Account cannot be covered by another health plan except "permitted" insurance products.

YES NO

IF YOU ANSWERED NO TO THE ABOVE, YOU ARE NOT ELIGIBLE TO ESTABLISH A QUALIFIED HEALTH SAVINGS ACCOUNT.

AGREEMENT: By signing this signature card you agree that the account will be governed by our Consumer Deposit Account Agreement. Among other things, this means that each term defined in that agreement has the same meaning here. You acknowledge receipt of that agreement; our Privacy Notice; the Truth in Savings disclosure; the fee schedule; and electronic fund transfer disclosure. You have read those documents and agree to them, all of which are part of this agreement.

X

Signature of Account Holder	Date
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FOR COMMERCIAL BANK USE ONLY:

OPENED BY: _____ DATE OPENED: _____ DATE IDENTIFICATION VERIFIED: _____

Account Number: _____

OFAC Checked

HSA Beneficiary Designation Form

NAME:	SSN:
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I hereby certify that if I die before distribution has been completed, the value of my account shall be distributed to the person(s) named below:

PRIMARY BENEFICIARY

Name:	Relationship:
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DOB: (mm/dd/yyyy)	SSN:
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Street Address:	
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City/State/Zip:	
------------------------	--

Percentage (must total 100%):	
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Name:	Relationship:
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DOB: (mm/dd/yyyy)	SSN:
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Street Address:	
------------------------	--

City/State/Zip:	
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Percentage (must total 100%):	
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CONTINGENT BENEFICIARY

Name:	Relationship:
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DOB: (mm/dd/yyyy)	SSN:
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Street Address:	
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City/State/Zip:	
------------------------	--

Percentage (must total 100%):	
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Name:	Relationship:
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DOB: (mm/dd/yyyy)	SSN:
--------------------------	-------------

Street Address:	
------------------------	--

City/State/Zip:	
------------------------	--

Percentage (must total 100%):	
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The above individual(s) or entity shall be my primary and/or contingent beneficiary(ies). If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary beneficiary. If more than one primary beneficiary is designated and no distribution percentages are indicated, the beneficiaries will be deemed to own equal share percentages in the HSA. Multiple contingent beneficiaries with no share percentage indicated will also be deemed to share equally. If any primary or contingent beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining beneficiary(ies) shall be increased on a pro rate basis. If no primary beneficiary(ies) survives me, the contingent beneficiary(ies) shall acquire the designated share of my Health Savings Account.

This section should be reviewed if either the trust or the residence of the HSA holder is located in a community property state and the HSA holder is married. Due to important tax consequences of giving up one's community property interest, individuals signing this section should consult with a competent legal or tax advisor.

CURRENT MARITAL STATUS

<input type="checkbox"/>	I am not married-I understand that if I become married in the future, I must complete a new HSA Designation of Beneficiary form.
<input type="checkbox"/>	I am married-I understand that if I choose to designate a primary beneficiary other than my spouse, my spouse must sign below.

I am the spouse of the above named HSA holder. I acknowledge that I have received a fair and reasonable disclosure of my spouse's property and financial obligations. Due to the important tax consequences of giving up my interest in this HSA, I have been advised to see a tax professional. I hereby give the HSA holder any interest I have in the funds or property deposited in this HSA and consent to the beneficiary(ies) indicated above.

I assume full responsibility for any adverse consequences that may result. No tax or legal advice was given to me by the Custodian or designated representatives.

X	
SPOUSE SIGNATURE	DATE

X	
WITNESS SIGNATURE	DATE

HSA Enrollment Form

COMMERCIAL BANK

INITIAL DEPOSIT

Type of Initial Deposit		Type of Contribution Source	
<input type="checkbox"/>	Regular Contribution:	Year:	
<input type="checkbox"/>	Rollover Amount:	\$	Account Holder Deposit: \$
<input type="checkbox"/>	Trustee to Trustee Transfer		Employer Deposit: \$
In the case of a rollover, I certify that this contribution is a rollover contribution within the meaning of IRS Section 223, that the rollover is being made within 60 days of receipt, and that I have not received a rollover in the last 12 months.			

ORDERING FOR HSA CHECKS, VISA CHECK CARD & INTERNET BANKING

<input type="checkbox"/> Yes <input type="checkbox"/> No	I would like one (1) Free Starter HSA Check Package of 50 duplicate checks to be used for normal distributions only. <i>(subsequent orders will be automatically debited from your HSA)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	I would like a Visa Check Card for myself.
<input type="checkbox"/> Yes <input type="checkbox"/> No	I would like a Visa Check Card for my spouse. <i>(Only applicable with completed Authorized Signer form)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	I would like access to Internet Banking. e-mail address:

Purchases made with either the HSA Visa Check Card or HSA checks will be reported by Commercial Bank as "normal distributions." I understand that I should not use my HSA Visa Check Card or HSA checks for non-qualifying or non-medical purposes and that I am responsible for any IRS penalties. I understand that I should submit a Commercial Bank HSA withdrawal form for any non-medical transaction. I understand Commercial Bank will issue me a check or deposit the funds into a Commercial Bank account.

If I applied for a Visa Check Card to be used in conjunction with the account listed above. I agree that use of the Card will be subject to the terms and conditions contained in the Deposit Account Agreement and Disclosure and Regulation E Disclosure that have been provided to me. I authorize Commercial Bank to make any investigation of my credit, either directly or through any agency. I understand that Commercial Bank will retain this application and any other credit information, even if this Visa Check Card is not granted.

CUSTOMER AGREEMENT AND SIGNATURE

Account Services Provided by Commercial Bank

- 1) Periodic Health Savings Account statements showing activity in the account. This would include, but not be limited to, contributions received, withdrawals from the account, interest earned, and any other appropriate information concerning your account.
- 2) IRS Forms 1099-HSA, 5498-HSA, and other reports of the Custodian as required by the IRS.

Signatures Important: Please read before signing.

I understand the eligibility requirements for this type of HSA deposit I am making and I state that I do qualify to make the deposit. I have received a copy of the Application and the HSA Custodial Agreement. I understand that the terms and conditions which apply to this HSA are contained in this Application and the Agreement. I agree to be bound by those terms and conditions. Within seven (7) calendar days from the date I open this HSA I may revoke it by mailing or delivering a written notice to the custodian of the account.

I assume complete responsibility for:

- 1) Determining that I am eligible for an HSA each year I make a contribution.
- 2) Ensuring that all contributions I make are within the limits set forth by the tax laws.
- 3) The tax consequences of any contribution (including rollover contributions) and distributions.

X	
SIGNATURE OF ACCOUNT HOLDER	DATE
X	
WITNESS SIGNATURE	DATE

HSA Authorized Signer Agreement

COMMERCIAL BANK

****AUTHORIZED SIGNER LIMITED TO SPOUSE ONLY****

Account Owner

Account Number
(to be completed by Commercial Bank)

THE FOLLOWING INFORMATION MAY BE USED TO FURTHER IDENTIFY THE AUTHORIZED SIGNER FOR TELEPHONE INSTRUCTIONS, LARGE TRANSACTIONS OR IF A SIGNATURE VARIES.

Authorized Signer Information

Name:		Employment:	
SSN:		ID TYPE & #:	
DOB:		Birthplace:	
Phone #:		Mother's Maiden Name:	

AGREEMENT: The Authorized Agent signing below agrees that the Health Savings Account will be governed by the terms set forth in the Deposit Account Agreement and Disclosure, the Rate and Fee Schedule, the Funds Availability Policy Disclosure and the Electronic Funds Transfer Agreement and Disclosure, (if requested below), as amended by the Financial Institution from time to time. The Authorized Agent also acknowledges that he/she has received at least one copy of these deposit account documents.

X	
ACCOUNT OWNER SIGNATURE	DATE
X	
AUTHORIZED SIGNER SIGNATURE	DATE

Verification of Account Owner and Authorized Signer

I hereby verify the identities of the above account owner _____ and authorized signer _____ that his/her signature and photo from his/her driver's license or state ID match the signature(s) above.

STATE OF MICHIGAN

COUNTY OF _____

On this _____ day of _____, 20____, in and for said County, personally appeared instrument, who acknowledged the same to be _____ free act and deed.

_____, Notary Public
 _____ County, Michigan
 Acting in _____ County
 My Commission Expires: _____



**COMMERCIAL
BANK**

Health Savings Account

Verification of Individual Signature

X _____
Signature of Individual Owner of Health Savings Account

X _____
Date

STATE OF MICHIGAN

COUNTY OF _____

On this _____ day of _____, 20_____, in
and for said County, personally appeared _____ to me
known to be the same person described in and who executed the within instrument, who acknowledge
the same to be his/her free act and deed.

_____, Notary Public,
_____ County, Michigan.
Acting in _____ County.
My Commission Expires: _____

Health Savings Custodial Account
(Under section 223(a) of the Internal Revenue Code)

Do not file
with the Internal
Revenue Service

Name of account owner	Date of birth of account owner	Identifying number (see instructions)
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Address of account owner (Street address, city, state, ZIP code)

Name of custodian	Address or principal place of business of custodian
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The account owner named above is establishing this health savings account (HSA) exclusively for the purpose of paying or reimbursing qualified medical expenses of the account owner, his or her spouse, and dependents. The account owner represents that, unless this account is used solely to make rollover contributions, he or she is eligible to contribute to this HSA; specifically, that he or she: (1) is covered under a high deductible health plan (HDHP); (2) is not also covered by any other health plan that is not an HDHP (with certain exceptions for plans providing preventive care and limited types of permitted insurance and permitted coverage); (3) is not enrolled in Medicare; and (4) cannot be claimed as a dependent on another person's tax return.

\$ dollars in cash is assigned to this custodial account.

The account owner and the custodian make the following agreement:

Article I

1. The custodian will accept additional cash contributions for the tax year made by the account owner or on behalf of the account owner (by an employer, family member, or any other person). No contributions will be accepted by the custodian for any account owner that exceeds the maximum amount for family coverage plus the catch-up contribution.
2. Contributions for any tax year may be made at any time before the deadline for filing the account owner's federal income tax return for that year (without extensions).
3. Rollover contributions from an HSA or an Archer Medical Savings Account (Archer MSA) (unless prohibited under this agreement) need not be in cash and are not subject to the maximum annual contribution limit set forth in Article II.
4. Qualified HSA distributions from a health flexible spending arrangement or health reimbursement arrangement must be completed in a trustee-to-trustee transfer and are not subject to the maximum annual contribution limit set forth in Article II.
5. Qualified HSA funding distributions from an individual retirement account must be completed in a trustee-to-trustee transfer and are subject to the maximum annual contribution limit set forth in Article II.

Article II

1. For calendar year 2007, the maximum annual contribution limit for an account owner with single coverage is \$2,850. This amount increases to \$2,900 in 2008. For calendar year 2007, the maximum annual contribution limit for an account owner with family coverage is \$5,650. This amount increases to \$5,800 in 2008. These limits are subject to cost-of-living adjustments after 2008.
2. Contributions to Archer MSAs or other HSAs count toward the maximum annual contribution limit to this HSA.
3. For calendar year 2007, an additional \$800 catch-up contribution may be made for an account owner who is at least age 55 or older and not enrolled in Medicare. The catch-up contribution increases to \$900 in 2008 and \$1,000 in 2009 and later years.
4. Contributions in excess of the maximum annual contribution limit are subject to an excise tax. However, the catch-up contributions are not subject to an excise tax.

Article III

It is the responsibility of the account owner to determine whether contributions to this HSA have exceeded the maximum annual contribution limit described in Article II. If contributions to this HSA exceed the maximum annual contribution limit, the account owner shall notify the custodian that there exist excess contributions to the HSA. It is the responsibility of the account owner to request the withdrawal of the excess contribution and any net income attributable to such excess contribution.

Article IV

The account owner's interest in the balance in this custodial account is nonforfeitable.

Article V

1. No part of the custodial funds in this account may be invested in life insurance contracts or in collectibles as defined in section 408(m).
2. The assets of this account may not be commingled with other property except in a common trust fund or common investment fund.
3. Neither the account owner nor the custodian will engage in any prohibited transaction with respect to this account (such as borrowing or pledging the account or engaging in any other prohibited transaction as defined in section 4975).

Article VI

1. Distributions of funds from this HSA may be made upon the direction of the account owner.
2. Distributions from this HSA that are used exclusively to pay or reimburse qualified medical expenses of the account owner, his or her spouse, or dependents are tax-free. However, distributions that are not used for qualified medical expenses are included in the account owner's gross income and are subject to an additional 10 percent tax on that amount. The additional 10 percent tax does not apply if the distribution is made after the account owner's death, disability, or reaching age 65.
3. The custodian is not required to determine whether the distribution is for the payment or reimbursement of qualified medical expenses. Only the account owner is responsible for substantiating that the distribution is for qualified medical expenses and must maintain records sufficient to show, if required, that the distribution is tax-free.

Article VII

If the account owner dies before the entire interest in the account is distributed, the entire account will be disposed of as follows:

- 1. If the beneficiary is the account owner's spouse, the HSA will become the spouse's HSA as of the date of death.
2. If the beneficiary is not the account owner's spouse, the HSA will cease to be an HSA as of the date of death.

Article VIII

- 1. The account owner agrees to provide the custodian with information necessary for the custodian to prepare any report or return required by the IRS.
2. The custodian agrees to prepare and submit any report or return as prescribed by the IRS.

Article IX

Notwithstanding any other article that may be added or incorporated in this agreement, the provisions of Articles I through VIII and this sentence are controlling.

Article X

This agreement will be amended from time to time to comply with the provisions of the Code or IRS published guidance. Other amendments may be made with the consent of the persons whose signatures appear below.

Article XI

Article XI may be used for any additional provisions. If no other provisions will be added, draw a line through this space. If provisions are added, they must comply with the requirements of Article IX.

Account owner's signature Date
Custodian's signature Date
Witness' signature
(Use only if signature of account owner or custodian is required to be witnessed.)

General Instructions

Section references are to the Internal Revenue Code.

Purpose of Form

Form 5305-C is a model custodial account agreement that has been approved by the IRS. An HSA is established after the form is fully executed by both the account owner and the custodian.

Do not file Form 5305-C with the IRS. Instead, keep it with your records. For more information on HSAs, see Notice 2004-2, 2004-1 C.B. 269, Notice 2004-50, 2004-2 C.B. 196, Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans, and other IRS published guidance.

Definitions

Identifying Number. The account owner's social security number will serve as the identification number of this HSA. For married persons, each spouse who is eligible to open an HSA and wants to contribute to an HSA must establish his or her own account.

High Deductible Health Plan (HDHP). For calendar year 2007, an HDHP for self-only coverage has a minimum annual deductible of \$1,100 and an annual out-of-pocket maximum (deductibles, co-payments and other amounts, but not premiums) of \$5,500. In 2008, the \$1,100 minimum annual deductible remains the same and the annual out-of-pocket maximum increases to \$5,600.

Self-only coverage and family coverage under an HDHP. Family coverage means coverage that is not self-only coverage.

Qualified medical expenses. Qualified medical expenses are amounts paid for medical care as defined in section 213(d) for the account owner, his or her spouse, or dependents (as defined in section 152) but only to the extent that such amounts are not compensated for by insurance or otherwise.

Custodian. A custodian of an HSA must be a bank, an insurance company, a person previously approved by the IRS to be a custodian of an individual retirement account (IRA) or Archer MSA, or any other person approved by the IRS.

Specific Instructions

Article XI. Article XI and any that follow it may incorporate additional provisions that are agreed to by the account owner and custodian. The additional provisions may include, for example, definitions, restrictions on rollover contributions from HSAs or Archer MSAs (requiring a rollover not later than 60 days after receipt of a distribution and limited to one rollover during a one-year period), investment powers, voting rights, exculpatory provisions, amendment and termination, removal of custodian, custodian's fees, state law requirements, treatment of excess contributions, distribution procedures (including frequency or minimum dollar amount), use of debit, credit, or stored-value cards, return of mistaken distributions, and descriptions of prohibited transactions.