HSA APPLICATION

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 1-888-711-2837.

***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* _____ 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 $2,000.

PART IV: INVESTMENT SELECTION

Name of Investment	Total Investment Amount
1. Auer Growth 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 Auer Growth 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

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: _____

Type: Primary Contingent Share Percentage: _____% Relationship to IRA Owner: spouse non-spouse

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

Residence Address: _____

PART VII: BENEFICIARY DESIGNATION-CONTINUED

Type: Primary Contingent Share Percentage: _____% Relationship to IRA Owner: spouse non-spouse

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

Residence Address: _____

Type: Primary Contingent Share Percentage: _____% Relationship to IRA Owner: spouse non-spouse

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 Auer Growth Fund for the total amount.
By Wire	For wire instructions call Shareholder Services at 1-888-711-2837.
Other	_____

(Third party checks, counter checks, starter checks, traveler's checks, checks drawn on non-U.S. financial institutions, money orders, 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 X: SPOUSAL CONSENT

Complete this section only if you, the HSA Owner, have your legal residence in a community or marital property state and you wish to name a beneficiary other than or in addition to your spouse as primary beneficiary. This section may have important tax consequences to you and your spouse so please consult with a competent advisor prior to completing. If not currently married and you marry in the future, you must complete a new beneficiary designation that includes the spousal consent provisions.

CONSENT OF SPOUSE

By signing below, I acknowledge that I am the spouse of the HSA Owner and agree with and consent to my spouse's designation of a primary beneficiary other than, or in addition to, me. I have been advised to consult a competent advisor and I assume all responsibility regarding this consent. The Custodian has not provided me any legal or tax advice.

Signature of Spouse

X_____ Date: _____

Witness

X_____ Date: _____

PART XI: AUTHORIZED SIGNER

To permit someone else (such as your spouse) to authorize payments from your HSA, complete the information below and have the authorized person sign the "Acknowledgement" section at bottom.

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

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

U.S. Citizen Resident Alien (Country)

For mailing outside of U.S., provide:

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

PART XII: ACKNOWLEDGEMENT

By signing this *HSA Application*, I certify that the information I have provided is true, correct, and complete, and the Custodian may rely on what I have provided. I have read and received copies of this *HSA Application*, *IRS Form 5305-C*, and *Disclosure Statement (*including the applicable fee schedule). I agree to be bound to their terms and conditions. I understand that the Custodian has no duty or responsibility to determine whether my HDHP complies with the requirements of Section 223 of the Internal Revenue Code nor to determine or validate whether distributions I take from my HSA are used to pay for qualifying medical expenses. I assume all responsibilities for the HSA transactions I conduct, and I will indemnify and hold the Custodian harmless from any consequences related to executing my directions. If I have indicated any amounts as "carryback" contributions, I understand the contributions will be credited for the prior tax year. I have been advised to seek competent legal and tax advice and have not been provided any such advice from the Custodian.

Signature of HSA Owner

X_____ Date:_____

Signature of HSA Trustee/Custodian Representative

X _____ Date:_____

Signature of Authorized Signer:

X_____ Date:_____

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 _____ **X** _____

Representative's Signature Supervisor's Signature

PART XIV: MAILING INSTRUCTIONS

Please send completed application to:

Regular Mail Delivery
Auer Growth Fund
P.O. Box 46707
Cincinnati, OH 45246-0707

Overnight Delivery
Auer Growth Fund
225 Pictoria Dr, Suite 450
Cincinnati, OH 45246

