HSA APPLICATION

The Sound Mind Investing Funds

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 1-877-764-3863.

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 ______

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.

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***Note:** The Funds' initial investment minimum is $2,500 per each Fund or $1,000 if systematic investment plan of $100 or more is established.

PART IV: INVESTMENT SELECTION

Name of Investment	Total Investment Amount
1. Sound Mind Investing Fund (SMIFX)	$
2. Sound Mind Investing Balanced Fund (SMILX)	$

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 funds 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 Sound Mind Investing Funds to initiate investments into my mutual fund accounts according to the following frequency:

☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Twice Each Month ☐ Monthly ☐ Other (Check months below)

☐ January ☐ January ☐ January ☐ January ☐ January ☐ January ☐ January
☐ July ☐ July ☐ July ☐ July ☐ July ☐ July ☐ July

Fund ______________________ Amount $ ______________ Day of Month (1st, 15th, etc.) ________

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.

Enter your checking or savings account information:

Name: ______________________________

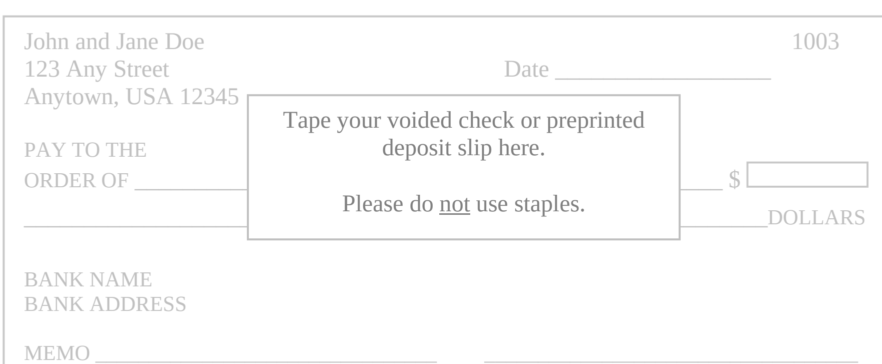
Name of Bank: ______________________________ Bank's Phone Number: ________________

Bank Address: ______________________________ ABA Routing Number: ________________

City: ______________________________ State: ______ Zip Code: ____________

Name(s) on Bank Account: ______________________________ Bank Account Number: ________________

Account Type: ☐ Checking ☐ Savings



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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: ____

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.

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PART VIII: ELECTRONIC COMMUNICATION

The completion of this section is OPTIONAL.

You can enjoy the convenience of receiving annual reports, transaction confirmations, and account statements online rather than having them mailed to you. You'll get your information faster while receiving fewer bulky mailings to fill your mailbox. Plus you'll help the environment and reduce the funds' expenses. To opt-in, simply check the box below and provide your email address.

When documents are available, you will receive an email message informing you of their availability online. For investment confirmations and account statements, the email will provide a link to our secure site where you will be prompted to sign in. You may then view your confirmation or account statement by clicking on 'Statements' at the top of the page. To review new prospectuses, annual and semi-annual reports, you will be sent an email with an attached document in PDF format for download.

The Sound Mind Investing Funds may change this notification without prior notice at any time. You may at any time request a paper copy of the Funds' prospectus, annual and semi-annual reports, or statements by calling us Monday through Friday, 9:00AM to 5:00PM Eastern Time, at 1-877-764-3863, or writing us at Sound Mind Investing Funds, PO Box 6110, Indianapolis IN 46206.

☐ **Authorization to discontinue mailing of paper statements -** By checking this box, I authorize the Sound Mind Investing Funds to send my shareholder communications electronically to the email address I am providing, rather than mailing me paper copies of these communications. I understand that I may discontinue electronic services and start receiving paper statements at my discretion.

Email Address: ____

PART IX: DUPLICATE ACCOUNT STATEMENT

☐ Yes, please send a duplicate statement to:

Name: ____

Physical Address: ____ City: __________________________ State: _________ Zip: __________

PART X: PAYMENT METHOD

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

☐ **By Check** Enclose a check payable to Sound Mind Investing Funds for the total amount.

☐ **By Wire** For wire instructions call Shareholder Services at 1-877-764-3863.

☐ **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 XI: 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: ____

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PART XII: 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*

PART XIII: 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 XIV: 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 XV: MAILING INSTRUCTIONS

Please send completed application to:

<u>Regular Mail Delivery</u>
Sound Mind Investing Funds
P.O. Box 6110
Indianapolis, IN 46206-6110

<u>Overnight Delivery</u>
Sound Mind Investing Funds
2960 N. Meridian Street Suite 300
Indianapolis, IN 46208

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