Individual HSA Attestation

Attestation of the intent to install a Health Savings Account
upon approval of the Madison National Life High Deductible Health Plan

Attestation of HSA Establishment

I acknowledge that this **High Deductible Health Plan** rate is exclusively available when this health plan will be used as a Qualified High Deductible plan in conjunction with an active and funded Health Savings Account (HSA). Health Savings Accounts must be activated within 60 days after the High Deductible plan has been issued for Coverage.

I understand that, if an HSA is not activated or if an HSA is discontinued, the premium rates for the High Deductible Health Plan will change. I further understand and accept that the initial rate guarantees do not apply to the rate change resulting from an HSA not being activated within 60 days.

To qualify for the High Deductible Health Plan HSA rates:

- Sign this attestation of the intention to create an HSA account
- If you already have an HSA account, please attach a copy of the most recent account statement that you intend to use with this High Deductible plan to eliminate the need for this information later.

To verify a Health Savings Account is established, IAC will require from me a copy of the Health Savings Account statement or written acknowledgement from the Health Savings Account custodian as proof that such account is established and funded (unless already submitted with this attestation as indicated above). Verification will be solicited by IAC within the first 6 months of being insured under the High Deductible Health Plan and annually thereafter, as determined by IAC.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any Health Savings Account custodian or it's administrator to release information affirming the existence of an active Health Savings Account on my behalf to Insurer's Administrative Corporation (IAC) or its authorized Administrator or their legal representatives. Any information obtained will not be released by IAC except to persons or organizations performing business or legal services in connection with establishing the proper insurance premium rates for my insurance coverage as may be otherwise lawfully permitted or required or as I further authorize. (A photocopy of this authorization shall be valid as the original. This authorization is valid for thirty (30) months from the date shown below.)

______________________________	______________________________
Applicant Name (please print)	Applicant Signature
______________________________	______________________________
Name of HSA custodian	Phone Number

This completed form should be submitted with your application for insurance.
If it becomes detached, submit it to:

IAC Underwriting
PO Box 37947
Phoenix, AZ 85069-7947
or fax to (602) 906-4713