HEALTHCARE ASSOCIATES CREDIT UNION
The healthy way to bank®
1151 East Warrenville Road
Naperville, Illinois 60563
Contact Center: 630.276.5555
or 800.942.0158 toll-free
hacu.org

MEMBERSHIP APPLICATION AND AGREEMENT

Eligibility. You qualify for a membership through Your: ☐ Family Name _____ ☐ Family Account # _____
☐ Association/Employment Name _____ ☐ Community Charter _____

Account Type(s): ☐ Savings ☐ Checking ☐ Vacation Club ☐ Money Market ☐ Super Money Market
☐ Christmas Club ☐ Term Share Certificate; _____ *(term)* ☐ IRA Term Share Certificate; _____ *(term)*

Account Ownership: ☐ Individual ☐ Joint ☐ POD ☐ Trust ☐ UTMA ☐ Estate

IMPORTANT INFORMATION ABOUT PROCEDURE[S] 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 You for Your name, address, date of birth, and other information that will allow Us to identify You. We may also ask to see Your driver's license or other identifying documents.

Primary Member Information

☐ Member ☐ Trust ☐ Other Specify: _____ Are You a Non-Resident Alien? ☐ Yes ☐ No

Full Name (As it appears on government issued ID)	Address	City	State	Zipcode

Social Security Number	Birth Date	How did You hear about Us?	Mother's Maiden Name	Password

Home Phone	Cell Phone	Driver's License Number	State	Issue Date	Expiration Date

E-Mail Address	Employer	Occupation	Work Phone	Ext.

Joint Owner 1 Information

☐ Joint Owner ☐ Trustee ☐ Other Specify: _____

Full Name (As it appears on government issued ID)	Address	City	State	Zipcode

Social Security Number	Birth Date	Mother's Maiden Name

Home Phone	Cell Phone	Driver's License Number	State	Issue Date	Expiration Date

E-Mail Address	Employer	Occupation	Work Phone	Ext.

Joint Owner 2 Information

☐ Joint Owner ☐ Trustee ☐ Other Specify: _____

Full Name (As it appears on government issued ID)	Address	City	State	Zipcode

Social Security Number	Birth Date	Mother's Maiden Name

Home Phone	Cell Phone	Driver's License Number	State	Issue Date	Expiration Date

E-Mail Address	Employer	Occupation	Work Phone	Ext.

Payable-On-Death Account Beneficiary Designation

In the event of Your death, You hereby designate the following beneficiary(ies).

Name _____ Address _____ DOB_____ SSN _____ Relationship _____
Name _____ Address _____ DOB_____ SSN _____ Relationship _____
Name _____ Address _____ DOB_____ SSN _____ Relationship _____
Name _____ Address _____ DOB_____ SSN _____ Relationship _____

Taxpayer Identification and Backup Withholding

Under penalties of perjury, You certify: (1) that the number shown on this form is Your correct taxpayer identification number (or the minor beneficiary's correct taxpayer identification number if the Account is established under the Uniform Gift/Transfers to Minors Act); (2) that You are not subject to backup withholding either because You have not been notified that You are subject to backup withholding as result of a failure to report all interest dividends, or the Internal Revenue Service (IRS) has notified You that You are no longer subject to backup withholding; (3) You are a U.S. person (including a U.S. resident alien); and (4) You are exempt from FATCA reporting.

INSTRUCTION TO SIGNER. If You have been notified by the Internal Revenue Service (IRS) that You are subject to backup withholding due to payee underreporting and You have not received a notice from the IRS that the backup withholding has terminated, You must strike out the language in part (2) of the statement above.

DO NOT STRIKE OUT ANY MATERIAL UNLESS YOU ARE SUBJECT TO BACKUP WITHHOLDING BY THE FEDERAL GOVERNMENT.

We will be unable to open an Account for You without a taxpayer identification number.

UTMA Account

For UTMA (Uniform Transfers to Minors Act) Accounts, You understand that the gift of money to the Minor named on this Application, which gift shall be deemed to include all dividends thereon and any future additions thereto, is irrevocable and is made in accordance with, and is to include all provisions of, the Illinois Uniform Transfers to Minors Act (the Act) as it is now and in the future. You further understand that the age of delivery from the Custodian to the Minor will occur upon the minor's age of 21, under the Act.

Joint Owner 1 is named as custodian for the Primary Member under the Illinois Uniform Transfers to Minors Act.

Designation of Successor Custodian. You appoint _____ (Name of Successor Custodian) as Successor Custodian of the gift property described in the gift transfer above. Such appointment will take effect: 1) when and in the event of Your resignation, death, incompetence, or legal incapacitation; and 2) when We deliver said account, together with a true copy of this instrument of designation, into the custody of the Successor Custodian named above. Upon receipt of actual or written notice of such event, You direct Us to make such delivery.

_____
Signature of Custodian

Revocable Living Trust

You hereby certify that:

(1) This is a revocable living trust. Name of Trust _____;
(2) The Trustee(s) can accomplish all banking transactions including the deposit and withdrawal of funds;
(3) The Trust Agreement appoints:

_____

_____
as Successor Trustee(s) upon death, legal incapacitation, resignation or incompetence of the (both) Settlor(s) who shall have all the powers identified herein;

(4) You understand that the Credit Union will rely on the accuracy of the foregoing information and We will continue to do so until We receive notice in writing that this certification has been revoked. You indemnify Us from any liability and costs We may incur by reason of such reliance. Upon Our request, We shall be entitled to a copy of the trust and any related documents.

You waive all right, title and interest which You may now have as an individual or joint owner of the account funds and transfer ownership of this account to the revocable living trust named above.

You agree to be bound by the terms and conditions of this Account with HealthCare Associates Credit Union and the Credit Union's bylaws, rules and regulations in effect, which are subject to changes from time to time.

Lien Impressment and Set-Off. You agree that We may impress and enforce a statutory lien upon any and all individual, joint or living trust Accounts with Us to the extent You owe Us any money and We may enforce Our right to do so without further notice to You. We have the right to set-off any of Your money or property in Our possession against any amount You owe Us. The right of set-off and Our impressed lien does not extend to any Keogh, IRA or similar tax deferred deposit You may have with Us. If Your Account is owned jointly, Our right of set-off and Our impressed lien extends to any amount owed to Us by any of the joint Owners.

We will recognize the signatures below in their trustee capacity, regardless of such designation as trustee, when authorizing any transaction for this account.

Signature of Settlor/Trustee of above Trust

Signature of Settlor/Co-Trustee of above Trust

Signature of Settlor/Co-Trustee of above Trust

Signature of Settlor/Co-Trustee of above Trust

Member Proxy Statement

You do hereby voluntarily constitute and appoint the members of the Board of Directors of this Credit Union, who are qualified and acting directors at the time this proxy is used, as proxies to cast all votes to which You are entitled, for the election of directors, mergers and any matter with regard to which credit union shareholders are entitled to vote by proxy, as the said directors or a majority of them see fit, at all annual or special meetings of the members of HealthCare Associates Credit Union hereafter held and any adjournment thereof, from time to time and year to year, until and unless this proxy is cancelled by You. You further authorize the said proxies to designate a person or committee to cast the vote or votes in such manner and for such candidates as the said proxy shall determine, and as permitted by law. You may revoke this proxy by indicating below, naming Yourself or another party, who will retain Your voting rights. You may attend a special meeting and vote in person.

☐ Yes ☐ No Signature X _____ Primary Member (Please Print)_____ Date _____

Signatures

You hereby apply for membership with HealthCare Associates Credit Union. You warrant the truth of the information contained in Your application for membership and/or in subsequent representations to Us. You realize that such information will be relied upon by Us in determining Your membership eligibility. You hereby authorize Us, Our employees and agents to investigate and verify any information provided to Us by You. By signing below, You agree to be bound by the terms and conditions found within Your application for membership and to the bylaws, rules and regulations of HealthCare Associates Credit Union in effect from time to time. You further acknowledge receiving a copy of the Agreements and Disclosures related to Your Account(s) and You agree to be bound by the terms and conditions found therein. If Your application for membership is a joint application, any liability created by the use of Your Account is joint and several. You authorize any person, association, firm, corporation or personnel office to furnish information concerning Your affairs upon Our request, including, but not limited to, providing credit and employment history information. In addition to establishing a primary Savings Account, You may also from time to time request additional Accounts and/or Account Services be established on Your behalf and/or the addition of joint owner(s) of Your Account(s). Your signature below is Your continuing authorization for HealthCare Associates Credit Union to follow Your written or verbal instructions to do so and You agree that Your continuing authorization will remain in effect unless We receive written instructions to the contrary. You hereby authorize Us to recognize any of the signatures subscribed herein in the payment of funds or the transaction of any business for Your Account(s).

The Internal Revenue Service does not require Your consent to any provision of this document other than the certifications required to avoid backup withholding.

Applicant's (Primary Member) Signature Date

Joint Owner #1 Signature Date

Joint Owner #2 Signature Date