AZZAD FUNDS

Mail Completed Form to:
Azzad Funds
C/O Mutual Shareholder Services
8000 Town Centre Dr. Ste 400
Broadview Heights, OH 44147
Make checks payable to: Azzad Funds

HSA Application

Use this form to open a Health Savings Account. For assistance completing this form, please call 888-862-9923.
All personal information requested below must be provided or we will not be able to open your account.
For questions about eligibility or qualified distributions from a HSA, please contact your insurance broker.

Part I. HSA Owner Information

ATTACH COPY OF DRIVER'S LICENSE- **REQUIRED**

Name _____Soc. Sec. # _____Date of Birth _____

Street Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Employer_____

Occupation _____ City _____ State _____ Zip _____

Part II. Employer's Information (for Employer Plans Only skip if individual plan)

Business Name _____EIN Tax ID # _____

Contact Person Name _____ Telephone Number _____

Street Address _____ City _____ State _____ Zip _____

Part III. Contribution Information

Source of Funds (Select One) Employer Plans: Do NOT complete this section if your HSA contributions are coming directly from your employer.

A. Choose Type of Contribution: _____ Regular _____ Rollover _____ Transfer (complete Transfer Form)

B. Choose Tax Year: _____ Current Year or _____ Prior Year (if left unfilled, will be applied to current year)

Part IV. How do you wish to invest this amount?

☐ Azzad Ethical Fund (ADJEX) for the amount of $_____ or _____% (minimum $500)

☐ Azzad Wise Capital Fund (WISEX) for the amount of $_____ or _____% (minimum $400)

Part V. Automated Contributions

If you want to set up monthly contributions to your HSA from your checking account, complete the following. **You must attach a voided check from the account you would like to withdraw from**. Please note: bounced checks will be charged $30. Deposits will begin as soon as administratively possible:

Amount $_____ Day of Month (choose one): _____ 10th or _____ 20th

Bank Name: _____ Routing Number: _____ Account Number: _____

_____Checking Account OR _____Savings Account

Part VI. Beneficiary Designation

I hereby designate the following primary beneficiary(ies) to receive payment of the value of my HSA upon my death. In the event that my primary beneficiary(ies) do not survive me, the funds are to be designated to my contingent beneficiary(ies). Note: If you do not indicate a percentage and more than one person is designated, the funds will be equally distributed among the beneficiary(ies). You may change your beneficiary(ies) at any time by giving written notice to the custodian.

A. Primary Beneficiary(ies):

Percentage Share %	Name	Social Security Number	Relationship	Birth Date

B. Contingent Beneficiary(ies):

Percentage Share %	Name	Social Security Number	Relationship	Birth Date

Part VII. 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 **Date**

Part VIII. SIGNATURES (REQUIRED)

By signing below, I certify that I am eligible to establish an HSA and certify the following:

- I am not able to be claimed as a dependent on someone else's tax return.
- I am covered under a qualifying High Deductible Health Plan (HDHP), effective _____.
- I am not covered under any other insurance plan that is not an HDHP (with limited exceptions).
- I am not enrolled in Medicare.

NOTE: Eligibility is determined on the first day of each month. If you are not an eligible individual for all 12 months of the year, the annual contribution limit may be prorated. For assistance in determining your eligible contribution amount, consult your tax advisor.

_____ _____

Authorized Signer Signature **Date**