New Account Agreement

Health Savings Account

For office use only
Reg# _____
SBS# _____

If you have questions or need help filling out this form, call us toll-free any time at **1-800-SATURNA (1-800-728-8762)**. Be sure you complete all steps or your application cannot be processed.

Mail completed forms and contributions to:
(Email or fax is not accepted)

Saturna Capital
P.O. Box N
Bellingham, WA 98227-0596

Section A. Type of Coverage and Funding

Type of Insurance Coverage

❍ **Individual**

❍ **Family** (Participant and spouse and/or child)

Initial Funding Source:

❍ **Check** - *Must be imprinted with name of account owner*

Section B. Account Holder Information

Primary Owner

Full Legal Name

Preferred Salutation *(optional)*: ❍ Mr. ❍ Mrs. ❍ Ms. ❍ Dr.

❍ Single ❍ Married ❍ Divorced ❍ Widowed

Citizenship

❍ US Citizen

❍ US Resident Alien

Social Security Number or Tax ID Number

Date of Birth (MM-DD-YYYY)

ID Type: ❍ Driver's License ❍ Passport ❍ State ID ❍ Other Government ID

State/Country of Issuance

A legible photocopy of the Primary Owner's driver's license, passport, or other government-issued identity document is required.

Address

Physical / Street Address *(Required - P.O. boxes are not accepted)*

City | State | Zip

Mailing Address *(optional)*

City | State | Zip

Preferred Phone

Alternate Phone

Email:

Section C. Beneficiary Designation

Make a copy of this page if you wish to add more beneficiaries. ***Note: You may not name yourself as beneficiary.***

Primary Beneficiary(ies):

Primary Beneficiary Full Legal Name | Preferred Salutation *(optional)*: ❍ Mr. ❍ Mrs. ❍ Ms. ❍ Dr. | Relationship

Social Security Number or Tax ID Number | Date of Birth (MM-DD-YYYY)

Address | Percentage %

City | State | Zip

Preferred Phone | Alternate Phone

Primary Beneficiary Full Legal Name | Preferred Salutation *(optional)*: ❍ Mr. ❍ Mrs. ❍ Ms. ❍ Dr. | Relationship

Social Security Number or Tax ID Number | Date of Birth (MM-DD-YYYY)

Address | Percentage %

City | State | Zip

Preferred Phone | Alternate Phone

Secondary Beneficiary(ies):

Secondary Beneficiary Full Legal Name | Preferred Salutation *(optional)*: ❍ Mr. ❍ Mrs. ❍ Ms. ❍ Dr. | Relationship

Social Security Number or Tax ID Number | Date of Birth (MM-DD-YYYY)

Address | Percentage %

City | State | Zip

Preferred Phone | Alternate Phone

Secondary Beneficiary Full Legal Name | Preferred Salutation *(optional)*: ❍ Mr. ❍ Mrs. ❍ Ms. ❍ Dr. | Relationship

Social Security Number or Tax ID Number | Date of Birth (MM-DD-YYYY)

Address | Percentage %

City | State | Zip

Preferred Phone | Alternate Phone

You may wish to consult your legal adviser to ensure that this form complies with your will and with your state's laws of testamentary disposition. If you have any questions about this form, please contact Saturna Capital Corporation at 1-800-SATURNA (1-800-728-8762).

Section D. Trusted Contact *(optional)*

In the event of suspected financial exploitation or fraud, Saturna Capital and its affiliates are authorized to contact the Trusted Contact person and disclose information about this account to address possible financial exploitation, to confirm the specifics of your current contact information, health status, or the identity of any legal guardian, executor, trustee or holder of a power of attorney, or as otherwise permitted by regulations.

Full Legal Name | Preferred Salutation *(optional)*: ❍ Mr. ❍ Mrs. ❍ Ms. ❍ Dr. | SSN or Tax ID *(optional)*

Email | Date of Birth (MM-DD-YYYY)

Address

City | State | Zip

Preferred Phone | Alternate Phone

Section E. Investment Selection

Investment Selection Instructions

Step 1: Choose the funds in which you want to invest.

Step 2: Indicate the dollar amount or percentage for each fund selection.

Step 3: Make separate checks payable to each selection.

Investment Allocation

Affiliated Funds*

❒	**Amana Growth** *Institutional*	$	or	%
❒	**Amana Developing World** *Institutional*	$	or	%
❒	**Amana Income** *Institutional*	$	or	%
❒	**Amana Participation** *Institutional*	$	or	%
❒	**Sextant Growth** *Z Shares*	$	or	%
❒	**Sextant International** *Z Shares*	$	or	%
❒	**Sextant Core**	$	or	%
❒	**Sextant Global High Income**	$	or	%
❒	**Sextant Short-Term Bond**	$	or	%
❒	**Sextant Bond Income**	$	or	%
❒	**Saturna Sustainable Equity**	$	or	%
❒	**Saturna Sustainable Bond**	$	or	%

* To link a bank account and/or set up automatic investment, complete the Saturna *Electronic Funds Transfer Form* (found on www.saturna.com/forms#/saturna-capital)

Section F. Signature

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

By signing this document, I certify that:

- I have full right, power, authority and legal capacity to establish an Health Savings Account and to make the investments selected.
- I understand and agree to all terms and conditions set forth in this Saturna Capital Health Savings Account Application and Custodial Agreement.
- I have read and understood the HSA Brochure (Disclosure Statement) at least seven days prior to my signing this document.
- I authorize Saturna Capital and/or its affiliates (Saturna Trust Company, Saturna Brokerage Services, Saturna Investment Trust, and/or Amana Mutual Funds Trust, together "Saturna") to verify my identity through an identity verification service and to use information provided by that service to determine whether to establish my account, or, once my account is opened, whether to maintain my account or limit services. If, after making reasonable efforts, Saturna is unable to verify my identity, I understand Saturna is authorized to take any action permitted by law, including closing my account and redeeming my account at the net asset value calculated the day the account is closed.
- I authorize telephone and/or internet exchange and redemption services to be automatically activated when my account is opened. I will contact Saturna in writing to terminate these services. Additional documents may be required.
- I authorize Saturna and its employees to act on any instructions believed to be genuine for any service authorized on this form. Saturna has reasonable procedures to verify the identity of the shareowner and when these procedures are followed, Saturna and its employees are not liable for losses that may occur from acting on such instructions.
- I have read and agree to be bound by the terms of the Prospectus(es) or Summary Prospectus(es) of the mutual fund(s) I have selected.
- I understand that my property may be transferred to the appropriate state if no activity occurs in the account within the time period specified by state law.
- I understand no share certificates will be issued.
- I certify, under penalties of perjury, that my Social Security Number is correct and that I am not subject to backup withholding under the provisions of § 3406(a)(1)(C) of the Internal Revenue Code.

Primary Owner or Custodian

Print Name

Date (MM-DD-YYYY):

Signature

X

Please note: Saturna cannot accept digital signatures.

For Saturna Use Only

Investment Professional Printed Name

Date (MM-DD-YYYY):

Signature

X

Principal Printed Name

Date (MM-DD-YYYY):

Signature

X

Form **5305-B**

(Rev. October 2016)

Department of the Treasury
Internal Revenue Service

Health Savings Trust Account

(Under section 223(a) of the Internal Revenue Code)

Do not file with the Internal Revenue Service

Name of account owner (grantor)	Date of birth of account owner

Address of account owner (Street address, city, state, ZIP code)

Name of trustee	Address or principal place of business of trustee
Saturna Trust Company	1300 N. State St., Bellingham, WA 98225

The account owner named above is establishing this health savings account (HSA) exclusively for the purpose of paying or reimbursing qualified medical expenses of the account owner, his or her spouse, and dependents. The account owner represents that, unless this account is used solely to make rollover contributions, he or she is eligible to contribute to this HSA; specifically, that he or she: (1) is covered under a high deductible health plan (HDHP); (2) is not also covered by any other health plan that is not an HDHP (with certain exceptions for plans providing preventive care and limited types of permitted insurance and permitted coverage); (3) is not enrolled in Medicare; and (4) cannot be claimed as a dependent on another person's tax return.

$ _____ dollars in cash is assigned to this trust account.

The account owner and the trustee make the following agreement:

Article I

1. The trustee will accept additional cash contributions for the tax year made by the account owner or on behalf of the account owner (by an employer, family member, or any other person). No contributions will be accepted by the trustee for any account owner that exceeds the maximum amount for family coverage plus the catch-up contribution.
2. Contributions for any tax year may be made at any time before the deadline for filing the account owner's federal income tax return for that year (without extensions).
3. Rollover contributions from an HSA or an Archer Medical Savings Account (Archer MSA) (unless prohibited under this agreement) need not be in cash and are not subject to the maximum annual contribution limit set forth in Article II.
4. Qualified HSA distributions from a health flexible spending arrangement or health reimbursement arrangement must be completed in a trustee-to-trustee transfer and are not subject to the maximum annual contribution limit set forth in Article II.
5. Qualified HSA funding distributions from an individual retirement account must be completed in a trustee-to-trustee transfer and are subject to the maximum annual contribution limit set forth in Article II.

Article II

1. For calendar year 2011, the maximum annual contribution limit for an account owner with single coverage is $3,050. This amount increases to $3,100 in 2012. For calendar year 2011, the maximum annual contribution limit for an account owner with family coverage is $6,150. This amount increases to $6,250 in 2012. These limits are subject to cost-of-living adjustments after 2012.
2. Contributions to Archer MSAs or other HSAs count toward the maximum annual contribution limit to this HSA.
3. For calendar year 2009 and later years, an additional $1,000 catch-up contribution may be made for an account owner who is at least age 55 or older and not enrolled in Medicare.
4. Contributions in excess of the maximum annual contribution limit are subject to an excise tax. However, the catch-up contributions are not subject to an excise tax.

Article III

It is the responsibility of the account owner to determine whether contributions to this HSA have exceeded the maximum annual contribution limit described in Article II. If contributions to this HSA exceed the maximum annual contribution limit, the account owner shall notify the trustee that there exist excess contributions to the HSA. It is the responsibility of the account owner to request the withdrawal of the excess contribution and any net income attributable to such excess contribution.

Article IV

The account owner's interest in the balance in this trust account is nonforfeitable.

Article V

1. No part of the trust funds in this account may be invested in life insurance contracts or in collectibles as defined in section 408(m).
2. The assets of this account may not be commingled with other property except in a common trust fund or common investment fund.
3. Neither the account owner nor the trustee will engage in any prohibited transaction with respect to this account (such as borrowing or pledging the account or engaging in any other prohibited transaction as defined in section 4975).

Article VI

1. Distributions of funds from this HSA may be made upon the direction of the account owner.
2. Distributions from this HSA that are used exclusively to pay or reimburse qualified medical expenses of the account owner, his or her spouse, or dependents are tax-free. However, distributions that are not used for qualified medical expenses are included in the account owner's gross income and are subject to an additional 20 percent tax on that amount. The additional 20 percent tax does not apply if the distribution is made after the account owner's death, disability, or reaching age 65.
3. The trustee is not required to determine whether the distribution is for the payment or reimbursement of qualified medical expenses. Only the account owner is responsible for substantiating that the distribution is for qualified medical expenses and must maintain records sufficient to show, if required, that the distribution is tax-free.

Article VII

If the account owner dies before the entire interest in the account is distributed, the entire account will be disposed of as follows:

1. If the beneficiary is the account owner's spouse, the HSA will become the spouse's HSA as of the date of death.
2. If the beneficiary is not the account owner's spouse, the HSA will cease to be an HSA as of the date of death. If the beneficiary is the account owner's estate, the fair market value of the account as of the date of death is taxable on the account owner's final return. For other beneficiaries, the fair market value of the account is taxable to that person in the tax year that includes such date.

Article VIII

1. The account owner agrees to provide the trustee with information necessary for the trustee to prepare any report or return required by the IRS.
2. The trustee agrees to prepare and submit any report or return as prescribed by the IRS.

Article IX

Notwithstanding any other article that may be added or incorporated in this agreement, the provisions of Articles I through VIII and this sentence are controlling. Any additional article in this agreement that is inconsistent with section 223 or IRS published guidance will be void.

Article X

The Custodian or Trustee may amend this Agreement in any respect (including retroactively) so that the Agreement may conform with applicable provisions of the Internal Revenue Code ("Code"), or with any other applicable law as in effect from time to time, or to make such other changes to this Agreement as the Custodian or Trustee deems advisable. Any amendment made to comply with the Code, or applicable law, does not require the grantor's consent. The grantor will be deemed to have consented to any other amendment unless, within 30 days from the date the Custodian or Trustee mails the amendment, the grantor notifies the Custodian or Trustee in writing that the grantor does not consent and that the Account should be distributed or transferred to another Trustee or Custodian.

Article XI

The Trustee or Custodian may be removed or may resign at any time. As a condition of resignation or removal, a successor Trustee or Custodian shall be appointed, provided that any such successor shall satisfy the requirements of the Code. Upon the successor's acceptance of appointment, the assets of the Account(s) shall be transferred to the successor, provided, however, a portion of the Account(s) may be reserved for payment of any liabilities that may constitute a charge against the Account(s). Upon acceptance of appointment, the successor shall be vested with all power of the Custodian or Trustee pursuant to this Agreement. The Custodian or Trustee shall not be liable for the acts or omissions of any predecessor or successor to it. In the event that no successor accepts an appointment, the custodial or trusteed Account(s) shall be terminated, and the assets of the Account(s), reduced by the amount of any unpaid fees, liabilities or expenses, will be distributed to the grantor (or following the death of the grantor, the beneficiary).

Account owner's signature ---------- Date ----------

Trustee's signature ---------- Date ----------

Witness' signature ----------

(Use only if signature of account owner or trustee is required to be witnessed.)

What's New

Additional Tax Increased. For tax years beginning after December 31, 2010, the additional tax on distributions not used for qualified medical expenses increases from 10% to 20%.

General Instructions

Section references are to the Internal Revenue Code.

Purpose of Form

Form 5305-B is a model trust account agreement that has been approved by the IRS. An HSA is established after the form is fully executed by both the account owner and the trustee. The form can be completed at any time during the tax year. This account must be created in the United States for the exclusive benefit of the account owner.

Do not file Form 5305-B with the IRS. Instead, keep it with your records. For more information on HSAs, see Notice 2004-2, 2004-2 I.R.B. 269, Notice 2004-50, 2004-33 I.R.B. 196, Pub. 969, Health Savings Accounts and Other Tax-Favored Health Plans, and other IRS published guidance.

Definitions

Identifying Number. The account owner's social security number will serve as the identification number of this HSA. For married persons, each spouse who is eligible to open an HSA and wants to contribute to an HSA must establish his or her own account. An employer identification number (EIN) is required for an HSA for which a return is filed to report unrelated business taxable income. An EIN is also required for a common fund created for HSAs.

High Deductible Health Plan (HDHP). For calendar year 2011, an HDHP for self-only coverage has a minimum annual deductible of $1,200 and an annual out-of-pocket maximum (deductibles, co-payments and other amounts, but not premiums) of $5,950. In 2012, the $1,200 minimum annual deductible remains the same and the annual out-of-pocket maximum increases to $6,050. For calendar year 2011, an HDHP for family coverage has a minimum annual deductible of $2,400 and an annual out-of-pocket maximum of $11,900. In 2012, the $2,400 minimum annual deductible remains the same and the annual out-of-pocket maximum increases to $12,100. These limits are subject to cost-of-living adjustments after 2012.

Self-only coverage and family coverage under an HDHP. Family coverage means coverage that is not self-only coverage.

Qualified medical expenses. Qualified medical expenses are amounts paid for medical care as defined in section 213(d) for the account owner, his or her spouse, or dependents (as defined in section 152) but only to the extent that such amounts are not compensated for by insurance or otherwise. With certain exceptions, health insurance premiums are not qualified medical expenses.

Trustee. A trustee of an HSA must be a bank, an insurance company, a person previously approved by the IRS to be a trustee of an individual retirement account (IRA) or Archer MSA, or any other person approved by the IRS.

Specific Instructions

Article XI. Article XI and any that follow it may incorporate additional provisions that are agreed to by the account owner and trustee. The additional provisions may include, for example, definitions, restrictions on rollover contributions from HSAs or Archer MSAs (requiring a rollover not later than 60 days after receipt of a distribution and limited to one rollover during a one-year period), investment powers, voting rights, exculpatory provisions, amendment and termination, removal of trustee, trustee's fees, state law requirements, treatment of excess contributions, distribution procedures (including frequency or minimum dollar amount), use of debit, credit, or stored-value cards, return of mistaken distributions, and descriptions of prohibited transactions. Attach additional pages if necessary.

Banking Authorization (EFT) and Automatic Investment Form

Use this form to link your bank account to your Saturna account and/or set up periodic investment.

A. Client Information

Account Owner / Custodian / Name of Trust

Full Legal Name

Date of Birth (MM-DD-YYYY)

Joint Owner / Minor / Authorized Signer *(if applicable)*

Full Legal Name

Date of Birth (MM-DD-YYYY)

Account Number

Preferred Phone

Email

Mail or fax completed forms to:
Saturna Capital
P.O. Box N
Bellingham, WA 98227-0596
Fax: (360) 734-0755

B. Bank Information

❒ Add new bank account

If a linked bank account already exists, please choose option below:

❒ Keep previously linked bank account and add additional bank account

❒ Remove existing bank account(s) and replace with new bank account

Bank Name

❒ Checking ❒ Savings

ABA / Routing number

Account number

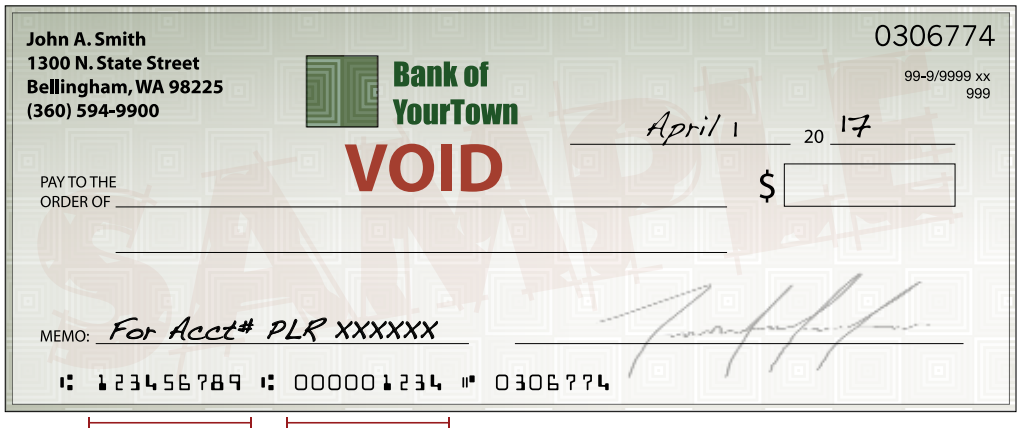
Owner's Name(s) on Bank Account

Please allow at least three (3) business days for processing. Supporting bank documentation must be submitted with your request.

Acceptable supporting documentation for a bank account includes:

* MICR encoded check with the full account name imprinted *(temporary checks are not accepted)*
* Bank account statement including the full account name, full account number, and bank name
* Letter written by an employee of the bank providing the full account name, number and routing number. This letter must be on bank letterhead and signed by an authorized employee of your bank.

At least one name on the bank account must match one of the Saturna account holders.



C. Automated Investment Plan *(optional)*

Complete this section to initiate automated periodic investments into your account.

		$25 Minimum Per Fund *after initial minimum*	Specify Period		Start Date (MM-DD-YYYY)
❒	**Amana Income**	$	❒ Monthly	❒ Quarterly	
❒	**Amana Growth**	$	❒ Monthly	❒ Quarterly	
❒	**Amana Developing World**	$	❒ Monthly	❒ Quarterly	
❒	**Amana Participation**	$	❒ Monthly	❒ Quarterly	
❒	**Sextant Growth**	$	❒ Monthly	❒ Quarterly	
❒	**Sextant International**	$	❒ Monthly	❒ Quarterly	
❒	**Sextant Core**	$	❒ Monthly	❒ Quarterly	
❒	**Sextant Global High Income**	$	❒ Monthly	❒ Quarterly	
❒	**Sextant Short-Term Bond**	$	❒ Monthly	❒ Quarterly	
❒	**Sextant Bond Income**	$	❒ Monthly	❒ Quarterly	
❒	**Idaho Tax-Exempt Fund**	$	❒ Monthly	❒ Quarterly	
❒	**Saturna Sustainable Equity**	$	❒ Monthly	❒ Quarterly	
❒	**Saturna Sustainable Bond**	$	❒ Monthly	❒ Quarterly	

Form must be received with enough processing time prior to selected "start date" or automated investments will begin the following month. If no start date is chosen, automatic payments will start being processed on the 21st day of each month. To cancel or change periodic investments, please call 1-800-SATURNA.

D. Signatures

By signing this form, I authorize Saturna Capital to add or change the bank account linked to my Saturna Capital accounts to purchase shares or send redemption proceeds via EFT. If I completed Section C, I acknowledge that I have received and read a current prospectus and agree to be bound by its terms. If my banking instructions have changed, there will be a 15 day hold on redemptions via EFT. There is no fee to use the EFT service through Saturna Capital, although other financial institutions may charge transaction fees.

Any changes to joint accounts require the signatures of both account owners.

Establishing a standing authorization is required to transfer funds electronically between my Saturna account and my account at another United States financial institution. It is the policy of Saturna Capital to use consumer reports in connection with establishing an electronic fund transfer service and for any other authorized purpose outlined in the FCRA [15 U.S.C. § 1681b]. Such inquiries into a consumer report will be used for legitimate business purposes, where it is necessary for establishing electronic fund transfers in connection with a business transaction that is initiated by me or to review an account to determine whether I continue to meet the terms of the account. Any other purposes will be in accordance with Saturna's privacy statement

By signing this form, I authorize Saturna to disclose information and receive information from a third-party consumer reporting agency, in connection with my request to establish electronic fund services.

In the event my request is denied, or the services are suspended or closed on the basis, in whole or in part, from the information in the consumer report, Saturna Capital will provide a notice of adverse action to me. Written and/or electronic notices will contain the following information:

- Summary of my rights under FCRA
- Adverse action was based on information in the consumer report;
- Consumer reporting agency did not make the decision.
- Consumer reporting agency name, address, and telephone number
- Consumer's right to obtain a free consumer report within 60 days; and
- Consumer's right to dispute the accuracy or completeness of information contained in the consumer report

Signature _____ Date _____

Joint Signature _____ Date _____