VyStar Credit Union

Clay County Board of Commissioners

Affidavit and Indemnity Agreement

Visa Health Savings Debit Card

Authorized User

Date: 11/12/2009 VyStar Member Number:

Member Name: VyStar Health Savings Account Number:

I (the above referenced VyStar Member) agree to and understand the following:

- I am the primary owner of the above referenced Health Savings Account at VyStar Credit Union.
- I authorize VyStar to issue a Visa Health Savings Debit Card to the following individual. I authorize the following individual authority to perform transactions on my Visa Health Savings Account at VyStar Credit Union by using the Visa Health Savings Debit Card only. This individual does not have any other authority or rights to the Health Savings Account, nor does the individual have authority to receive account transaction information.

  Name of Authorized Signer:

  Authorized Signer's Member Number:

  Relationship to above VyStar Member:

- I am and will be held liable for all transactions performed by the authorized signer and transactions performed on my VyStar Health Savings Account.
- I have received VyStar's Visa Health Savings Debit Card Agreement and Disclosure and agree to the terms and conditions.
- I hereby agree to indemnify and hold harmless VyStar Credit Union from any loss, claims from other parties, or damages, including reasonable attorney's fees and collection fees, arising from their actions in relying on the above referenced agreement.

_____ _____

Member's Signature Date

NOTARY

State of Florida County of _____

Dated this _____day of _____, _____.

(day) (month) (year)

Witness my hand and official seal:

_____ To me personally known.

_____ Identified to me by Driver's License Number _____, State of _____

Sworn and subscribed to before me: _____

My Commission Expires: ___/___/___ Notary Stamp: