CLEAR FORM

Health Savings Account (HSA)	Financial Institution Name Branch Name or Number Institution ID # / Participant ID #

HEALTH SAVINGS ACCOUNT (HSA) DISTRIBUTION REQUEST

HSA ACCOUNT OWNER INFORMATION

Name of Account Owner

Account Owner Mailing Address

City | State | Zip

Social Security Number | Date of Birth

AMOUNT OF THE DISTRIBUTION

❑ Lump Sum $_____ *(the HSA is being closed)*

❑ Partial* $_____ *(the HSA still holds funds)*

**This option is only available to the Account Owner and NOT beneficiaries.*

DISTRIBUTION REASON *(the reason selected will be reported to the IRS)*

❑ Normal *(this includes distributions taken from this HSA to pay for qualified and non-qualified medical expenses)*

❑ Excess Contribution *(this applies when removing an excess contribution)*

$_____ *(amount of the excess contribution being removed)*

$_____ *(amount of Net Income Attributable being removed, if being removed prior to tax filing deadline plus extensions)*

❑ Disability

❑ Death Date of death _____/_____/_____ *(attach a certified copy of death certificate and complete page 2)*

SIGNATURES AND CERTIFICATIONS

I understand that Health Savings Accounts are intended to be used only to pay for qualified medical expenses and that distributions for any other purposes may cause the amount withdrawn to be subject to taxes and/or penalties under the Internal Revenue Code. I understand that it is solely my responsibility to retain records to document the application of these funds.

Account Owner Signature ✕ | Date

Important: For Death Distributions, see page 2.

HEALTH SAVINGS ACCOUNT (HSA) DISTRIBUTION REQUEST

FOR DEATH DISTRIBUTIONS ONLY

(Complete this section only if a beneficiary is taking a distribution after the death of the HSA Account Owner.)

Name of Beneficiary

Relationship to Account Owner ❑ Spouse ❑ Estate ❑ Other

Mailing Address of Beneficiary

City | State | Zip

Social Security Number or Tax ID Number, if Estate | Date of Birth

SPOUSAL BENEFICIARY ACKNOWLEDGMENT

I, _____ *(name of Spouse Beneficiary),* as the spouse of the above-named HSA Account Owner and Beneficiary of the HSA held at _____ *(name of Financial Institution)* understand, as a result of being designated as a beneficiary, that this HSA became my HSA, as of the death of the HSA Account Owner. I acknowledge that I am subject to the terms and conditions and the Trust Account Agreement which govern this account.

SIGNATURES

Signature of Spouse Beneficiary ✕ | Date

NON-SPOUSAL BENEFICIARY ACKNOWLEDGMENT

I understand that as a non-spouse designated beneficiary of this HSA, as of the date of death of the Account Owner, that the IRS no longer considers this account to be an HSA. I understand that I am not eligible to transfer or rollover these funds to my own HSA.

Beneficiary Signature ✕ | Date

BANK USE ONLY

Financial Institution Representative Signature ✕ | Date

Printed Name of Financial Institution Representative

Provide the fair market value of the HSA as of the date of death of the HSA owner $_____.