Request for Distribution

Account Holder Information

Employer Name (Please Print) ______________________ HSA Account Number ______________

Account Holder Last Name ______________________ First Name ______________________ Middle Initial ___

Address ______________________ City ______________________ State ______ Zip ________

Social Security Number ______________ Home Phone (_____)__________ Work Phone (_____)__________

Employee E mail Address (if any)____

Date of Birth _______ /_______ /_______ Date of Death (if applicable) _______ /_______ /_______
mm/dd/yyyy mm/dd/yyyy

Check One:
- ❒ Please enter my receipts in the ClaimsVault™. No reimbursement requested. – *Complete Section1 ONLY.*
- ❒ Please enter my receipts in the ClaimsVault™. Yes, reimbursement requested. – *Complete Sections 1 and 2.*
- ❒ Reimbursement ONLY, No claims to submit for ClaimsVault™ at this time. – *Complete Section 2 ONLY.*
- ❒ Send Refund to my Employer.

1. Expense Detail

If this distribution from your HSA is for a Qualified Medical Expense and you want your Plan Service Provider to certify that the expenses are qualified for tax filing purposes, then please supply medical expense information below. Use a copy of this form if you need more space.

Service Date (mm/dd/yyyy)	Receipt Attached	Patient Name	Relationship	Provider	Description of Service	Amount
						$
						$
						$
						$
						$
						$

2. Reason For Distribution and Payment Instructions (check one)

❒ Normal Qualified Distribution ❒ Non-Qualified Distribution ❒ Disability ❒ Death ❒ Other ______________________

❒ Withdrawal Excess Contributions & Earnings for Tax Year ________ ❒ Close Account and Distribute Remaining Balance (less $25.00 Closing Fee)

Requested HSA Withdrawal Amount $ ______________________

Payment Instructions (check one)

❒ Mail check to me (a fee of $3.00 for each check will apply) ❒ Deposit into my personal bank account on file

❒ **New** Account or **Change** Account: Name of Bank ______________________ Account Type: ❒ Checking ❒ Savings

Routing Transit Number
(All nine boxes must be filled)

Account Number
(Include hyphens, but not spaces and special symbols)

Employee's Certification for Disbursement

I certify that this distribution requested from my accounts was incurred by me (and/or my spouse and/or eligible dependents), was not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible Section 213(d) Medical Expenses and should be treated as a Tax-Free Distribution under my HSA. I will not use the expense reimbursed through this account as deductions or credits when filing my individual income tax return. Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

If this is a request to Close Account and Distribute Reamining Balance, by my signature below I acknowledge that there is a $25.00 Closeing Fee and that this Closing Fee will be deducted from mmy blanace prioror to distribution. I also acknowledge that I will no longer have access to my acount once it is closed and that my stored receipts (claims vault) and clims history will no longer be accessible.

HSA Owner's Signature ______________________________ **Date** _______/_______/_______
mm/dd/yy

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For fastest response, please FAX or EMAIL your forms.