

# Distribution

## HEALTH SAVINGS ACCOUNT

Review the following content thoroughly. Upon review, print the documents and obtain the required signatures, as applicable, to finish documenting the distribution from the account.

### OWNER INFORMATION

Last Name

First

MI

Tax ID

Date of Birth

Account Type

Account Number

Health Savings Account

### FINANCIAL ORGANIZATION INFORMATION

Financial Organization

Email

Phone

### DISTRIBUTION INFORMATION

☐ Distribute entire balance and close the account

#### Reason

For additional distribution reasons, contact your organization.

☐ Normal Distribution (Reason Code 1)

☐ Transfer to another HSA (Not Reported)

#### Distribution Method

☐ Cash

☐ Check payable to:

☐ Transfer to account#  
at

Account Type:

☐ HSA

☐ Non-health account (i.e., checking, savings)

Date of Distribution

Distribution Amount

\$

DISTRIBUTION SUMMARY

Total Amount

Financial Organization  
Penalties and Fees

Net Amount

INVESTMENT OPTIONS

Name	Investment Number	Amount to Distribute	Penalty/Fee Amount

SIGNATURE

By signing this **Distribution** document, I certify that the information I have provided is true and correct, and I authorize the Trustee to distribute my HSA as instructed above. I understand that I am responsible for ensuring I am eligible to authorize this distribution and I assume all responsibility for any consequences as a result of my actions. I will indemnify and hold the Trustee harmless from any consequences related to executing my instructions. I have not received any legal or tax advice from the Trustee and any assistance provided by the Trustee is not to be construed as such.

Print Account Owner Name

Account Owner Signature

Date

Print Trustee Representative Name

Trustee Representative Signature

Date