



BENEFICIARY DESIGNATION

This beneficiary designation overrides all previous designations for this HSA.

PART 1. HSA OWNER

Name (First/Mi/Last) _____
Social Security Number _____
Date of Birth _____ Phone _____
Email Address _____
Account Number _____ Suffix _____

PART 2. HSA TRUSTEE OR CUSTODIAN

To be completed by the HSA trustee or custodian
Name _____
Address Line 1 _____
Address Line 2 _____
City/State/ZIP _____
Phone _____ Organization Number _____

PART 3. BENEFICIARY DESIGNATION

I designate that upon my death, the assets in this account be paid to the beneficiaries named below. The interest of any beneficiary that predeceases me terminates completely, and the percentage share of any remaining beneficiaries will be increased on a pro rata basis. If no beneficiaries are named, my estate will be my beneficiary.

PRIMARY BENEFICIARIES *(The total percentage designated must equal 100%. If more than one beneficiary is designated and no percentages are indicated, the beneficiaries will be deemed to own equal share percentages in the HSA.)*

Name _____

Address _____

City/State/ZIP _____

Date of Birth _____ Relationship _____

Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____

Address _____

City/State/ZIP _____

Date of Birth _____ Relationship _____

Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____

Address _____

City/State/ZIP _____

Date of Birth _____ Relationship _____

Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____

Address _____

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Date of Birth _____ Relationship _____

Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____

Address _____

City/State/ZIP _____

Date of Birth _____ Relationship _____

Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____

Address _____

City/State/ZIP _____

Date of Birth _____ Relationship _____

Tax ID (SSN/TIN) _____ Percent Designated _____

CONTINGENT BENEFICIARIES on page 2

Name of HSA Owner _____, Account Number _____

CONTINGENT BENEFICIARIES (The total percentage designated must equal 100%. If more than one beneficiary is designated and no percentages are indicated, the beneficiaries will be deemed to own equal share percentages in the HSA. The balance in the account will be payable to these beneficiaries if all primary beneficiaries have predeceased the HSA owner.)

Name _____

Address _____

City/State/ZIP _____

Date of Birth _____ Relationship _____

Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____

Address _____

City/State/ZIP _____

Date of Birth _____ Relationship _____

Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____

Address _____

City/State/ZIP _____

Date of Birth _____ Relationship _____

Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____

Address _____

City/State/ZIP _____

Date of Birth _____ Relationship _____

Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____

Address _____

City/State/ZIP _____

Date of Birth _____ Relationship _____

Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____

Address _____

City/State/ZIP _____

Date of Birth _____ Relationship _____

Tax ID (SSN/TIN) _____ Percent Designated _____

Check here if additional beneficiaries are listed on an attached addendum. Total number of addendums attached to this HSA _____

PART 4. SPOUSAL CONSENT

Spousal consent should be considered if either the trust or the residence of the HSA owner is located in a community or marital property state.

CURRENT MARITAL STATUS

I Am Not Married – I understand that if I become married in the future, I should review the requirements for spousal consent.

I Am Married – I understand that if I choose to designate a primary beneficiary other than or in addition to my spouse, my spouse should sign below.

CONSENT OF SPOUSE

I am the spouse of the above-named HSA owner. I acknowledge that I have received a fair and reasonable disclosure of my spouse's property and financial obligations. Because of the important tax consequences of giving up my interest in this HSA, I have been advised to see a tax professional.

I hereby relinquish any interest that I may have in this HSA and consent to the beneficiary designation indicated above. I assume full responsibility for any adverse consequences that may result.

X _____

Signature of Spouse

Date (mm/dd/yyyy)

X _____

Signature of Witness

Date (mm/dd/yyyy)

Name _____

Address _____

City/State/ZIP _____

Date of Birth _____ Relationship _____

Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____

Address _____

City/State/ZIP _____

Date of Birth _____ Relationship _____

Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____

Address _____

City/State/ZIP _____

Date of Birth _____ Relationship _____

Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____

Address _____

City/State/ZIP _____

Date of Birth _____ Relationship _____

Tax ID (SSN/TIN) _____ Percent Designated _____

Name _____

Address _____

City/State/ZIP _____

Date of Birth _____ Relationship _____

Tax ID (SSN/TIN) _____ Percent Designated _____

PART 5. SIGNATURES

I understand that I may replace my beneficiary designations at any time by completing and delivering the proper form to the trustee or custodian. The trustee or custodian has provided no tax or legal advice to me regarding my beneficiary designations.

I designate the persons or entities named above as my primary and/or contingent beneficiaries of this HSA. I hereby revoke all prior beneficiary designations, if any, made by me.

X _____

Signature of HSA Owner

Date (mm/dd/yyyy)

X _____

Signature of Witness

Date (mm/dd/yyyy)