HealthSavings ADMINISTRATORS
Investing in a Healthy Future

Health Savings Account (HSA) Authorized Signer Form

Instructions: Complete this form to add or remove an authorized signer to the account.

PLEASE NOTE that you can complete this online at **HealthSavings.com.**

If you are completing this as a paper form, mail or fax your completed form to:

***HealthSavings* Administrators**
10800 Midlothian Tpke, Ste 240 • Richmond, VA 23235

Accountholder Information (All fields required)

First Name _____ Last Name _____ M.I._____

Social Security Number _____ **OR** Account Number _____

☐ This is a new address.

Street Address _____ Apt / Suite _____

City _____ State _____ ZIP Code _____

Remove Authorized Signer (If applicable; all fields required)

To remove an existing authorized signer, please provide the authorized signer's information below, then check the box next to "Remove this authorized signer."

☐ Remove this authorized signer.

First Name _____ Last Name _____ M.I._____

Social Security Number _____

Add Authorized Signer (If applicable; all fields required)

Since regulations require that only one individual own a health savings account (HSA), you may want your spouse and/or a third party to be an authorized signer to have access to your account. By completing all of the fields below, you are authorizing the person designated as authorized signer to access and initiate transactions on your account as your agent. Authorized signers must be 18 years or older.

First Name _____ Last Name _____ M.I._____

Social Security Number _____ Date of Birth *(mm/dd/yyyy)* _____
(Must be at least 18)

Complete this section **only** if debit card option is available on your account. If the debit card option is not available on your account, a debit card will **not** be ordered.

☐ This is the first authorized signer request submitted for my account. Please send a complimentary Visa® debit card to the individual listed above.

☐ This is a request to add an additional authorized signer. Please send a Visa® debit card to the person listed above and deduct $6 from my HSA.

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10800 Midlothian Tpke, Ste 240 Richmond, VA 23235 (p) 888.354.0697 (f) 804.726.1570 HealthSavings.com

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Signatures

If you wish to designate an authorized signer on your account, please complete all of the required fields. If you are unable to provide all of the required information on your authorized signer, they will not be added to your account. You hereby designate the following individual as an authorized signer on your health savings account. By designating an authorized signer on your account, you authorize the person designated as "Authorized Signer" to transact business with and give instructions to FPS Trust regarding your health savings account; make deposits or withdrawals by any means acceptable to FPS Trust, including paper and electronic methods such as ACH and Internet-generated transactions; receive and have access to account information, including account balances and transactions; endorse any instruments such as checks, orders or other documents for the payment of funds; and to otherwise serve as agent for your FPS Trust health savings account.

You specifically authorize FPS Trust, as custodian of your HSA, to rely upon this authorization and designation until such time, if any, that FPS Trust receives a written revocation of this authorization, and has had a reasonable time to act upon the revocation. You understand that you are responsible for ensuring that your authorized signer reads and understands the FPS Trust account documents which have been provided to you. You hold harmless and indemnify FPS Trust against any claims against or losses FPS Trust may suffer arising out of FPS Trust's reliance on this authorization, and release FPS Trust from any liability arising from such reliance, unless otherwise prohibited by law. You understand that you bear sole responsibility for any tax consequences that result from any actions taken by the authorized signer regarding your account.

NO PRESENT OR FUTURE OWNERSHIP OR RIGHT OF SURVIVORSHIP IS GIVEN TO THE AUTHORIZED SIGNER BY THIS AUTHORIZATION. UPON NOTICE TO FPS TRUST OF YOUR DEATH, THIS AUTHORIZATION TERMINATES, AND RIGHTS TO FUNDS IN YOUR ACCOUNT WILL BE TRANSFERRED TO YOUR BENEFICIARIES. IF YOU DID NOT NAME A BENEFICIARY, YOUR ACCOUNT BALANCE WILL ONLY BE PAYABLE TO YOUR ESTATE.

_____ _____

Accountholder Signature (Required) Date *(mm|dd|yyyy)*

_____ _____

Authorized Signer Signature (Required) Date *(mm|dd|yyyy)*

FOR OFFICE USE ONLY

Sales Director _____

Partner Code _____

Case Number _____

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