

Health Savings Account (HSA) Withdrawal Form

Instructions: Complete this form to make a withdrawal from your account. **PLEASE NOTE:** If you select the Electronic Deposit option for receiving your funds, you must print and complete this as a paper form, and mail with your check to the address below.

Mail completed form to:

HealthSavings Administrators/HSA xChange

P.O. Box 73688

North Chesterfield, VA 23235

Accountholder Information

First Name _____ Last Name _____ M.I. _____

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

Withdrawal

Withdrawal Amount \$ _____ **(This form cannot be used to close your account.)**

PLEASE NOTE: Funds are withdrawn from your cash balance first (if available) and then pro rationally from other available investment funds.

Withdrawal Method:

Paper Check

NOTE: A \$10 check processing fee will be deducted from your withdrawal amount and the check will be mailed to the address on file.* Please allow up to two weeks to receive your check. If sufficient funds are not available within 5 business days of receiving this request, it will be returned to you unprocessed.

**If you need to change your address, please log into your online account or complete our Address Change Form.*

Electronic Deposit to Your Personal Bank Account. The following information is required:

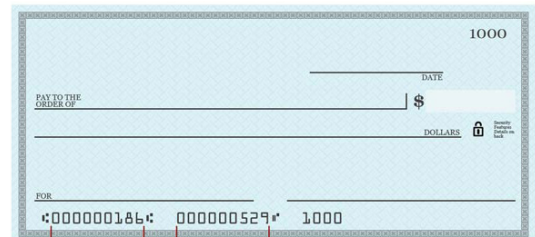
Bank Name _____

Routing Number _____

Account Number _____

Account Type: Checking Savings

Attach a voided check to this form. Starter checks, business checks, bank statements and deposit slips are not acceptable. If a check is not available, provide a letter from your bank on bank letterhead and signed by an authorized bank representative containing account information.



ABA ROUTING NUMBER ACCOUNT NUMBER

Change Contribution Instructions

Qualified medical expenses are defined in section 213(d) of the Internal Revenue Code, IRS Publication 502 and Revenue Ruling 2003-102, 2003-38 I.R.B. 559. HSA funds can be used to pay the qualified medical expenses for you, your spouse and tax dependents for expenses incurred after the HSA was established. **NOTE:** Tax penalties may apply to certain types of HSA distributions. Please consult with a tax professional if you are taking a distribution for any reason other than to pay or reimburse a qualified medical expense.

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Signature

I certify that I am the proper party to receive payment(s) from the health savings account (HSA) and that all information provided by me is true and accurate. I further certify that no tax advice has been given to me by *HealthSavings* or FPS Trust. All decisions regarding this withdrawal are my own. I expressly assume the responsibility for consequences which may arise from this withdrawal and I agree that *HealthSavings* or FPS Trust shall not be held responsible. I further understand that funds will be withdrawn from my cash/debit account first, then from investments (as needed), and I must maintain a balance of at least 5% in my investment funds to accommodate market fluctuations.

Accountholder Signature

Date (mm/dd/yyyy)

FOR OFFICE USE ONLY

Case Number _____