Health Savings Account (HSA)
Payment Information Form

To be completed by the Investment Firm/Agency.

Complete and return this form to:
Email: advisors@HealthSavings.com

Investment Firm/Agency

Investment Firm/Agency Name _____

Street Address *(P.O. boxes not accepted)* _____

City _____ State _____ ZIP _____

Phone _____ Fax _____ Website _____

RIA Firm Number *(if applicable)* _____ Branch ID Number *(if applicable)* _____

Primary Contact

First Name _____ Last Name _____

Phone _____ Email _____ IAR Rep ID *(if applicable)* _____

HSA Set Up Options

Payment is made to the Investment Firm/Agency quarterly via ACH. Please provide the information below.

Bank Name _____

Account Type *(i.e. Savings, DDA)* _____ Name on Account _____

Account Number _____ ABA Routing Number _____

Signature

Investment Firm/Agency

Authorized Signer Name *(printed)* _____ Title _____

_____ _____

Signature Date

FOR OFFICE USE ONLY

Case Number _____