Health Savings Account (HSA)
Company Contact Update Form

Instructions: Complete this form to update your company administrator.

Once completed, send your form to:

***HealthSavings* Administrators / HSA xChange**
Email: employers@HealthSavings.com

Company Information (Current information on file)

Company Name _____ Federal Tax ID # _____

This is a change to: ❍ Main Administrator* ❍ Administrator ❍ Billing Contact Change

*The main administrator is the only administrative user that will have the ability to add other administrative users.

An authorized representative must sign below in order for these changes to take effect.

Administrator and/or Billing Contact Change

❍ Add ❍ Edit ❍ Remove

First Name_____ Last Name _____ M.I._____

Telephone Number_____ Ext_____ Fax_____ Email Address _____

Authorized Representative Signature (NOTE: This form may NOT be signed by the new main administrator)

Privacy, the USA PATRIOT Act and the Employer Site — At FPS Trust, we respect the confidentiality of customer information. Some of the information we request is required by a federal law called the USA PATRIOT Act and regulations adopted by governmental agencies to implement it. This law requires FPS Trust to obtain, verify and record information that identifies each person or entity that opens an account. This information helps the government fight the funding of terrorism and money laundering activities. When you sign up for the employer site, we will ask you for your company's name and address. We will also ask you for an identification number such as your Social Security, EIN or Tax Identification number. This information will allow us to identify you. In some instances, we may also ask to see identifying documents. Please rest assured that all customer information is kept in the strictest confidence, unless required by law to be disclosed.

FPS Trust and *HealthSavings* are not responsible for any loss, injury or damage, whether direct, indirect, special, consequential, exemplary, economic or otherwise, caused by the use of the website or the unauthorized access of the website. The plan sponsor shall be solely responsible for requesting a password to be used by authorized users. Plan sponsor shall be solely responsible for the protection of such passwords to ensure that only authorized users access the website. Plan sponsor shall ensure that all authorized users comply with the terms and conditions of this agreement and shall be solely responsible for any failure by the authorized users to do so. Because the provided password can be used to access sensitive account information, all authorized users should treat the password with the same degree of care and confidentiality that they use to protect other sensitive financial data. All authorized users agree to not give the password or make it available to any person not authorized to access the website. Further, plan sponsor agrees to notify *HealthSavings* immediately should any previously authorized user become ineligible for access, so that the password may be deactivated.

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Authorized Representative Signature (NOTE: This form may NOT be signed by the new main administrator)

Authorized Representative Name _____ Title _____

_____ _____

Signature Date *(mm|dd|yyyy)*

FOR OFFICE USE ONLY

Case Number _____