Request for Distribution

HSAToday™

Account Holder Information

Employer Name (Please Print) _____ HSA Account Number _____

Account Holder Last Name _____ First Name _____ Middle Initial ___

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Home Phone (_____)_____ Work Phone (_____)_____

Employee E mail Address (if any)_____

Date of Birth _____/_____/_____ Date of Death (if applicable) _____/_____/_____
mm/dd/yyyy mm/dd/yyyy

Reason For Distribution (check one)

☐ Normal Qualified Medical Expenses ☐ Death ☐ Non-Qualified Withdrawal ☐ Disability

☐ Withdrawal Excess Contributions & Earnings for Tax Year _____ ☐ Close Account and Distribute Remaining Balance

Payment Instructions (check one)

Requested HSA Withdrawal Amount $ _____

☐ Mail check to me (a fee of $1.50 for each check will apply)

☐ Deposit into my personal bank account at this financial institution:

Name of Bank _____ Account Type: ☐ Checking ☐ Savings

Routing Transit Number
(All nine boxes must be filled)

Account Number
(Include hyphens, but not spaces and special symbols)

Expense Detail

If this distribution from your HSA is for a Qualified Medical Expense and you want your Plan Service Provider to certify that the expenses are qualified for tax filing purposes, then please supply medical expense information below. Use a copy of this form if you need more space.

Service Date (mm/dd/yyyy)	Receipt Attached	Patient Name	Relationship	Provider	Description of Service	Amount
						$
						$
						$
						$
						$
						$

Employee's Certification for Disbursement

I certify that this distribution requested from my accounts was incurred by me (and/or my spouse and/or eligible dependents), was not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible Section 213(d) Medical Expenses and should be treated as a Tax-Free Distribution under my HSA. I will not use the expense reimbursed through this account as deductions or credits when filing my individual income tax return. Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

HSA Owner's Signature _____ **Date** _____/_____/_____
mm/dd/yy

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For fastest response, please FAX or EMAIL your forms.