

Health Savings Account Death Beneficiary Change Form

This form is to make changes to beneficiary designations. Please note: in order to process this form, notarization is required.

* = Required Fields

Step 1 of 5: Account Holder Information

*HSA Account Holder Name (First, MI, Last)

 - -

*Social Security Number

*Employer Name (Do not abbreviate)

*Employee ID

Step 2 of 5: Designation of Death Beneficiary(ies)

- New Death Beneficiary(ies)** - The following individual(s) or entity shall be my primary and/or contingent death beneficiary(ies). **If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary death beneficiary.**
- Replace Death Beneficiary(ies)** - I designate the individual(s) or entity named below as my primary and/or contingent death beneficiary(ies) of this HSA and hereby revoke all prior death beneficiary(ies) designations, if any, made by me.
- Add Death Beneficiary(ies)** - I designate the individual(s) or entity named below as my primary and/or contingent death beneficiary(ies) of this HSA. This list supplements, but does not replace, the death beneficiary(ies) previously designated by me on the date specified.

(When adding death beneficiaries, if the share % of previously designated death beneficiary(ies) changes, restate all death beneficiaries and the corresponding share % if the previous percentages are no longer correct.)

If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary death beneficiary. If any primary or contingent death beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining death beneficiary(ies) shall be increased on a pro rata basis. If more than one primary death beneficiary is designated and no distribution percentages are indicated, the death beneficiaries will be deemed to own equal share percentages in the HSA. Multiple contingent death beneficiaries with no share percentage indicated will also be deemed to share equally. If no primary death beneficiary(ies) survives me, the contingent death beneficiary(ies) shall acquire the designated share of my HSA.

Name	Social Security Number	Birth Date	Address	Primary or Contingent		Relationship	Share %
				<input type="checkbox"/>	Primary		
				<input type="checkbox"/>	Contingent		
				<input type="checkbox"/>	Primary		
				<input type="checkbox"/>	Contingent		

Step 3 of 5: Marital Status

- I Am Not Married** - I understand that if I become married in the future, I must complete a new HSA Designation of Death Beneficiary Form.
- I Am Married** - I understand that if I choose to designate a primary death beneficiary other than my spouse, my spouse must sign below and have his/her signature notarized.

I am the spouse of the above-named HSA Account Beneficiary. I acknowledge that I have received a fair and reasonable disclosure of my spouse's property and financial obligations. Due to the important tax consequences of giving up my interest in this HSA, I have been advised to see a tax professional. I hereby give the HSA Account Beneficiary any interest I have in the funds or property deposited in this HSA and consent to the death beneficiary designation(s) indicated above. I assume full responsibility for any adverse consequences that may result. No tax or legal advice was given to me by the Custodian.

Spouse Signature

Date



Step 4 of 5: Spouse's Signature Notarization (only required if spouse is not the designated beneficiary)

State of _____

County of _____

On this, the _____ day of _____, 20____, before me a notary public, _____, personally appeared _____, satisfactorily proved to be the person whose name is subscribed to the within instrument, and acknowledged that he/she executed the same for the purposes therein contained.

In witness hereof, I hereunto set my hand and official seal.

Notary Public Signature _____

(seal)

Step 5 of 5: Authorized HSA Account Holder Signature

If this HSA is being established with a regular contribution, I certify that I am covered by a qualified high deductible health plan (HDHP), and that I am not covered by a health plan other than an HDHP that provides any of the same benefits as an HDHP. If this HSA is being established with a rollover or transfer contribution, I certify that the rollover or transfer assets are from another HSA or Archer Medical Savings Account (MSA). I certify that the information provided by me on the Application is accurate, and that I have received a copy of the Application and Custodial Agreement and Disclosure Statement and amendments thereto. I assume sole responsibility for all consequences found in the Application and Custodial Agreement and Disclosure Statement. I understand that I may revoke the HSA on or before seven (7) days after the date of establishment. I have not received any tax or legal advice from the Custodian, and I will seek the advice of my own tax or legal professional to ensure my compliance with related laws. I release and agree to hold the HSA custodian harmless against any and all claims or losses arising from my actions

*HSA Account Holder Signature

*Date