Health Savings Account-HSA

HSA DISTRIBUTION REQUEST FORM

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Instructions

1-This form is used to request a distribution from your HSA for one of the reasons indicated below.
NOTE: For distribution due to death, complete the Death Distribution Request Form.

2-Fax the completed form to the HSA Administrator: **AleraPay—FX: 585-641-7500**
OR Mail the completed form to: **AleraPay, 800 Parker Hill Drive-Suite 100, Rochester NY 14625**

3-For questions regarding changing your beneficiary, contact **AleraPay**, at **1-800-622-6233.**

Accountholder Information

Last Name	First Name	Middle Initial

Social Security Number	Employee ID and Employer (if applicable)

I direct the HSA Administrator to make a distribution from my HSA for the following reason *(choose only one reason per form)***:**

Normal/Disability/Prohibited Transaction Distribution

Amount of Distribution

$_____

❑ **Normal**—For payment of qualified medical expenses; save your receipts

❑ **Disability** – If the disability renders you unable to engage in any substantial gainful activity and it is medically determined that the conditional will last continuously for at least 12 months or lead to your death. Disability distributions are subject to ordinary income tax.

❑ **Prohibited Transaction** – use of HSA funds for anything other than a qualified medical expense; if not corrected in a timely manner, IRS penalties may be imposed.

Excess Contribution Removal

Amount of Excess Contribution

$_____

❑ **Excess Contribution Removal**
Date Excess Contribution Occurred: _____

Rollover / Transfer

For a request to close my account, I authorize the HSA Administrator to liquidate the investments in my HSA Investment Account and wait 10 days to allow outstanding debit card transactions to settle *(if debit card is applicable to my account)* before mailing the check for any remaining account balance, less applicable account closing fees.

❑ **Rollover–**Check will be made payable to HSA Accountholder and mailed to your address on file.

☐ Liquidate my entire account balance or ☐ $_____

Check one: ☐ This rollover WILL CLOSE my HSA account **OR** ☐ This rollover WILL NOT CLOSE my HSA account

The IRS Code limits the number of rollovers that may be taken, how quickly rollovers must be completed and how the trustee or custodian must report the transaction. If you need additional information, please contact your tax advisor. By selecting this option, you are certifying to the bank that you have satisfied the rules and conditions applicable to your rollover and that you are making an irrevocable election to treat the transaction as a rollover. The funds you receive from the distribution of an HSA must be deposited into another HSA within 60 days from when you receive them. You are entitled to one distribution per year per HSA which may be rolled over. You are entitled to roll over the same assets only once in a twelve (12) month period.

❑ **Transfer–**Check will be made payable to the receiving Administrator/Trustee/Custodian for the benefit of the HSA Accountholder and mailed to the address you provide below. It is the HSA Accountholder's responsibility to forward the check to the new Administrator/Trustee/Custodian.

☐ Liquidate my entire account balance or ☐ $_____

Check one: ☐ This transfer WILL CLOSE my HSA account **OR** ☐ This transfer WILL NOT CLOSE my HSA account

Name of Receiving Administrator/Trustee/Custodian _____

Address of Receiving Administrator/Trustee/Custodian _____

Authorization Signature

I certify that I am the HSA Accountholder or an individual authorized to execute this transaction. I have read and understand the instructions and any rules or conditions relating to this transaction. I assume full responsibility for this transaction and will not hold HSA Administrator or Healthcare Bank, a division of Bell Bank Trust liable for any adverse consequences that may result. I have not received tax or legal advice from HSA Administrator or Healthcare Bank and, if necessary, will seek the advice of a tax or legal professional to ensure my compliance with related laws. All information provided by me is true and correct and may be relied upon HSA Administrator and Healthcare Bank.

Signature of HSA Accountholder: _____ **Date:** _____

Office Use Only			