



# Health Savings Account (HSA) Distribution Form

## HSA OWNER INFORMATION

Name \_\_\_\_\_ HSA Account Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number (SSN) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Daytime Phone Number \_\_\_\_\_ Date of Death (if applicable) \_\_\_\_\_

Email Address (optional) \_\_\_\_\_

## DISTRIBUTION REASON Select One:

- Death (provide certified copy of death certificate)
  - Type of Beneficiary:  Spouse  Estate  Other
  - Distribution in:  Year of Death  After Year of Death
- Disability
- Prohibited Transaction Amount \$ \_\_\_\_\_
- Revocation (Closing within 7 days of account opening)
- Transfer
  - to spouse's HSA due to death
  - to former spouse's HSA due to divorce or legal separation
- Correction of Excess Contribution for the Tax Year \_\_\_\_\_
  - Amount of Excess \$ \_\_\_\_\_
  - by my tax-filing due date, including extensions
  - after my tax-filing due date, including extension

Recipient Information (Complete for Death and Transfer transactions)

Name \_\_\_\_\_ HSA Account Number (if applicable) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Taxpayer Identification Number (TIN)/SSN (if applicable) \_\_\_\_\_ Daytime Phone \_\_\_\_\_

## PAYMENT INSTRUCTIONS

Payment Method \_\_\_\_\_

Mail check to me  Return over contribution to my employer (name & address) \_\_\_\_\_

## SIGNATURES

I certify that I am the HSA owner, the beneficiary, or individual legally authorized to complete this form. I certify the accuracy of the information set forth in this form, and I authorize this transaction. I understand the First Horizon Msaver may require the completion of additional documents before processing any distributions. I understand that I am responsible for any consequences resulting from this distribution including taxes and penalties owed. I indemnify and hold the custodian/trustee harmless from any resulting liabilities. I acknowledge that the custodian/trustee cannot provide me with legal advice, and I agree to consult with a tax or legal professional for guidance.

X \_\_\_\_\_ X \_\_\_\_\_

Signature of HSA Owner/Beneficiary Date First Horizon Msaver Representative Signature Date

Please complete and return to First Horizon Msaver, P.O. Box 26106, Shawnee Mission, Ks 66225.

### Payment Detail (completed by First Horizon Msaver)

Fair Market Value of HSA as of Date of Death \$ \_\_\_\_\_ Earnings on Excess Contribution \_\_\_\_\_

Does this distribution close the HSA?  Yes  No Date of distribution \_\_\_\_\_