Lifetime Benefit Solutions

HSA DISTRIBUTION REQUEST FORM

Instructions

1. Use this form to request a distribution from your HSA for one of the reasons indicated below. **For death distributions, complete the HSA Death Distribution Request Form.**
2. Forward the completed form to: **Lifetime Benefit Solutions** at: **PO Box 211126, Eagan, MN 55121** or fax to: **(877) 256-7228.**
3. If you have any questions regarding distributions from your HSA, please call **(800) 327-7130**.

Accountholder Information

Last Name _____ First Name _____ Middle Initial _____

Social Security Number _____ Employee ID and Employer (if applicable) _____

Please liquidate ☐ my entire account balance or ☐ $ _____

This distribution ☐ will / ☐ will not close my HSA account (please check one).

If I am requesting account closure, I authorize Lifetime Benefit Solutions to liquidate the investments in my HSA Investment Account and wait 10 days to allow any outstanding debit card transaction (if debit card is applicable to my account) to settle before mailing the check for any remaining account balance, less any applicable account closing fee.

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

Distribution Type

☐ **Normal Distribution** – For payment of qualified medical expenses; save your receipts

Transaction expense Type (please all that apply)

☐ Chiropractic ☐ Medical ☐ Laboratory ☐ Healthcare Premium

☐ Dental ☐ Pharmacy ☐ Vision ☐ Other

Recipient/Patient:_____

☐ **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 $_____ Earnings on excess contribution $_____

Date excess contribution occurred _____

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

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.

Name of Receiving Administrator/Trustee/Custodian _____

Address of Receiving Administrator/Trustee/Custodian _____

Recipient Name and Account Number_____

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 Lifetime Benefit Solutions or WEX Inc. liable for any adverse consequences that may result. I have not received tax or legal advice from Lifetime Benefit Solutions or WEX Inc. 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 Lifetime Benefit Solutions and WEX Inc.

Signature of HSA Accountholder _____ Date _____