HSA Distribution Form

A valid photo ID must be attached to this request.

Employer Name / Plan Name

Your Name (Last Name, First Name) | Social Security Number | Date of Birth

Mailing Address | City | State/Territory | ZIP

Tel #: _____ E-mail Address: _____

How to Request a Lump Sum Distribution from your Account

1. Distribution Type

** Responsibility for ensuring that funds are used for qualified healthcare expenses fall solely on the account holder and not the trustee or custodian.*
** Account holder is responsible for tracking qualified healthcare expenses and penalties.*

☐ This withdrawal is for Qualified Tax-deductible Healthcare Expenses[1]

☐ This withdrawal is NOT for Qualified Healthcare Expenses

IMPORTANT REMINDER – If the withdrawal is NOT for Qualified Tax-deductible Healthcare Expenses, it will be treated as taxable income and, if under age 65, a 20% penalty may apply.

2. Form of Distribution

☐ Full Distribution of Account

☐ Partial Distribution $_____

3. Distribution Processing Instructions

☐ Process this request within 7 - 10 business days. **Deduct the $10 distribution processing fee from my account.**

☐ Process this request within 7 - 10 business days. **Enclosed is my check payment in the amount of $10.00 to cover the fee.**

How to Transfer Your Account Balance into another HSA

☐ I would like to transfer $_____ or _____% of my account balance to another HSA.

☐ I would like to transfer my account balance to the following HSA Account**, less the $50.00 for processing.**

New HSA Trustee:

Mailing Address | City | State/Territory | ZIP

Signatures: I certify the accuracy of the distribution reason selected above and I authorize the transaction. I agree to the terms of this Form and its instructions. I understand that I am responsible for any consequences resulting from this distribution including taxes and penalties owed. I agree to indemnify and to hold the Custodian/Trustee harmless from any tax, penalty, or other liability resulting from his distribution. I acknowledge that the Custodian/Trustee cannot provide legal advice and I agree to consult with my own tax professional if I need advice.

Signature of Accountholder or Beneficiary** | Date

ASC HSA Trustee/Notary as Witness to Signature | Date

Additional Information:

[1] Qualified Medical Expenses are expenses paid by you, your spouse, or your dependents for medical care as defined in section 213(d) (including nonprescription drugs as described in Revenue Ruling 2003-102, 2003-38 I.R.B. 559), but only to the extent the expenses are not covered by insurance or otherwise. The qualified medical expense must be incurred only after the HSA has been established.