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 (complete page 2)

☐ 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.

HSA Distribution Form

Please read the attached "Special Tax Notice Regarding Plan Payments" before completing this form.

Employer / Plan Name

Your Name (Last Name, First Name) Social Security Number

Distribution Payout Request

Note: All payments are made via ACH (Direct Deposit).

☐ Please issue a distribution paid directly to me equal to $_____ ☐ Gross Amount ☐ Net Amount or _____% of my vested balance. **I understand that there is a $10.00 processing fee for distributions.**

I have attached a voided check or bank certification that contains the valid routing number and bank account number (*Ask ASC about First Hawaiian Bank accounts*). I have also provided my physical address as required by the bank.

BANK NAME: _____

☐ Savings Account # _____ Routing # _____

☐ Checking Account # _____ Routing # _____

Attach VOIDED Check Here

Death Benefit Payout - Beneficiay Information

Death of Account Owner - Death Benefit payment will be made to (select one):

☐ Beneficiary - Spouse ☐ Beneficiary - Non-Spouse ☐ Alternate Payee (resulting from court order)

Beneficiary/ Payee Name (Last Name, First Name) Social Security Number Date of Birth

Mailing Address City State/Territory ZIP

Contact Number(s) E-mail Address

Certification: I have read this payment request and affirm that the above information and elections made are accurate and any payments made by the Trustee pursuant to the above (subject to terms of the Plan) will relieve the Trustee of any liability. I certify that the above information is true and correct to the best of my knowledge.

Signature of Beneficiary for Death Payout) Date Plan Administrator Signature or Notary as Witness to Participant Signature Date

[1]*If you have requested less than 100% of your vested balance to be rolled over, the remainder of your distribution will be issued as a separate check made payable to you with Federal Taxes Withheld at 20% on the taxable portion. State taxes will be withheld, where applicable.*