



# Health Savings Account Change Form

Instructions: Please complete boxes outlined in **RED**

## A: Personal Information

Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ First Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Apt #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
Marital Status: Single Married Divorced Widowed  
Gender: Male Female

## B: Type of Change [MUST SELECT OPTION(S) AND FILL IN INFORMATION]

### Name Change:

Previous Name: \_\_\_\_\_

New Name: \_\_\_\_\_

### Address Change:

Previous Address: \_\_\_\_\_

New Address: \_\_\_\_\_

### Contribution Amount Change:

Previous Contribution Amount: \_\_\_\_\_

New Contribution Amount: \_\_\_\_\_

### Beneficiary Change:

#### Primary Beneficiary:

Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ First Name: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Percentage of Benefit: \_\_\_\_\_  
Enroll Delete

Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ First Name: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Percentage of Benefit: \_\_\_\_\_  
Enroll Delete

#### Contingent Beneficiary:

Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ First Name: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Percentage of Benefit: \_\_\_\_\_  
Enroll Delete

Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ First Name: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Percentage of Benefit: \_\_\_\_\_  
Enroll Delete

**B: Type of Change [MUST SELECT OPTION(S) AND FILL IN INFORMATION]**

**Terminate HSA Coverage\***

**Cancellation Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

\*Subjected to contracted date – coverage may extend to last day of month.

**C: Acknowledgement of Coverage and Signature**

Name Printed:

Signature:

Signature Date: \_\_\_\_/\_\_\_\_/\_\_\_\_