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: _____/_____/_____