ebms
CONSUMER DRIVEN HEALTHCARE

HSA - Beneficiary Form

Instructions: Use this form to change an existing/already established Health Savings Account (HSA). Complete this form and return it through any of the following methods: **Mail** - Employee Benefit Management Services, Inc., P.O. Box 21367, Billings, MT 59104-1367; **Fax** - 844.791.8315; **Email** - EBMS_receipts@alegeus.com. Please direct questions to 866.857.8182.

Account Holder's Personal Information: ALL FIELDS REQUIRED (P.O. BOX NOT ACCEPTED)

First Name		MI		Last Name	
Social Security #	- -	or	Account # 8 digits, from statement		DOB (mm/dd/yyyy) / /

Designation of Beneficiary: The following individual(s) or entity shall be my primary and/or contingent beneficiary(ies). If neither primary nor contingent is indicated, the individual or entity will be deemed to be the primary beneficiary. If more than one primary beneficiary is designated and no distribution percentages are indicated the beneficiaries will be deemed to own equal share percentages in the account. Multiple contingent beneficiaries with no share percentage indicated will also be deemed to share equally. If a primary or contingent beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining beneficiary(ies) shall be increased on a pro-rated basis. If no primary beneficiary(ies) survives me, the contingent beneficiary(ies) shall acquire the designated share of my account. I understand that I may change or add beneficiaries at any time by completing and delivering the Account Maintenance form to Avidia Bank. Avidia Bank has provided no tax or legal advice to me regarding my beneficiary designation.

Name & Address of Individual (or Trust and Trustee)	Date of Birth (Creation date, if Trust)	Social Security# (TIN, if Trust)	Relationship	Primary or Contingent	Share %

Spousal Consent

This section should be reviewed if either the trust or the residence of the account holder is located in a community or marital property state and the account holder is married. Due to important tax consequences of giving up one's community property interest, individuals signing this section should consult with an independent legal or tax advisor.

CURRENT MARITAL STATUS

☐ I am not married – I understand that if I become married in the future, I must complete a new Designation of Beneficiary form.

☐ I am married – I understand that if I choose to designate a primary beneficiary other than my spouse, I am responsible for obtaining consent if required by law.

Signature

I authorize the individuals designated above to be added as Beneficiaries to my HSA and certify that the information provided above and attached hereto is accurate.

Signature _____ Date _____