



Health Savings Account (HSA) Designation of Beneficiary Form

Form Instructions: Use this form to designate a beneficiary or beneficiaries to receive your Health Savings Account (HSA) after your death. This Designation of Beneficiary Form will stay in effect until you submit another valid Designation of Beneficiary Form naming other beneficiaries or canceling all prior designations. The beneficiary designation(s) you provide on this form will automatically cancel all previous designations you submitted. Complete this form in accordance with the instructions. Do not cross out, erase, or otherwise change information you provide on this form. Please note, if you are married and intend to designate a beneficiary other than, or in addition to, your spouse, your spouse must consent in writing by signing this form. This form must be notarized. Please consult your tax advisor or an attorney when completing this form, as there may be tax and/or legal consequences to your designation.

Make a copy of this form for your records and send the original to ConnectYourCare. You will receive a confirmation of your designation once your form is processed.

Form Submission Checklist:

- You provide your name and last 4 digits of your Social Security Number on each page that you submit.
- You print legibly.
- You sign all pages you complete on the same date.
- Your spouse reviews and signs the Spousal Consent Section, if applicable.
- You do not alter this form or any information you provide on it.
- Your primary beneficiaries' shares add up to 100%.
- The shares of contingent beneficiaries, if any, total 100% for each primary beneficiary.
- The form is notarized.
- Mail the original to: ConnectYourCare, PO BOX 85960, 6300 Wayne Road, Westland, MI 48185

STEP 1: Account Holder Information

First Name:	Middle Name:	Last Name:	Date of Birth:
Address:		City:	State: Zip Code:
Social Security Number: (Only Last 4 Digits Required)		Account Number: (12 digits from your Welcome Kit or statement. Not your card number.)	
XXXX / XX / _____		_____	

STEP 2: Designation of Primary Beneficiaries

First Name of Primary Beneficiary (or Trust and Trustee Name)	Last Name of Primary Beneficiary	Address of Primary Beneficiary (or Trust and Trustee)	Date of Birth (mm/dd/yyyy) (Creation date, if Trust)	Social Security Number (TIN, if Trust)	Relationship	Share %
					<input type="checkbox"/> Spouse <input type="checkbox"/> Other Individual <input type="checkbox"/> Trust	
					<input type="checkbox"/> Spouse <input type="checkbox"/> Other Individual <input type="checkbox"/> Trust	
					<input type="checkbox"/> Spouse <input type="checkbox"/> Other Individual <input type="checkbox"/> Trust	
					<input type="checkbox"/> Spouse <input type="checkbox"/> Other Individual <input type="checkbox"/> Trust	
					<input type="checkbox"/> Spouse <input type="checkbox"/> Other Individual <input type="checkbox"/> Trust	
Total Share %:						



STEP 3: Designation of Contingent Beneficiaries

Do not complete this section if you are not naming contingent beneficiaries. You may designate one or more contingent beneficiaries for each primary beneficiary you name. The contingent beneficiary[ies] you name will receive the portion of the HSA that you designated for a specific primary beneficiary who dies before you. Each contingent beneficiary must be linked to a primary beneficiary. You cannot link a contingent beneficiary to another contingent beneficiary.

First Name of Contingent Beneficiary <i>(or Trust and Trustee Name)</i>	Last Name of Contingent Beneficiary	Address of Contingent Beneficiary <i>(or Trust and Trustee)</i>	Date of Birth <i>(mm/dd/yyyy) (Creation date, if Trust)</i>	Social Security Number <i>(TIN, if Trust)</i>	Contingent to which primary beneficiary? <i>(Enter Primary Beneficiary Name)</i>	Relationship	Share %
						<input type="checkbox"/> Spouse <input type="checkbox"/> Other Individual <input type="checkbox"/> Trust	
						<input type="checkbox"/> Spouse <input type="checkbox"/> Other Individual <input type="checkbox"/> Trust	
						<input type="checkbox"/> Spouse <input type="checkbox"/> Other Individual <input type="checkbox"/> Trust	
						<input type="checkbox"/> Spouse <input type="checkbox"/> Other Individual <input type="checkbox"/> Trust	
Total Share %:							

STEP 4: Account Holder Signature

I certify that I am the named Account Holder of the above-referenced Health Savings Account (“HSA”). By signing below, I certify that the information contained on this Beneficiary Designation Form is true and correct. Upon my death, all funds remaining in my HSA should be paid to the beneficiaries named on this form, unless superseded by a subsequent beneficiary designation properly executed by me. If my spouse is a named beneficiary, my spouse may choose to continue the HSA in his or his name, subject to Custodian’s approval. For any non-spouse beneficiary, the HSA terminates as of the date of my death. If I am naming beneficiaries other than, or in addition to my spouse, state law may require my spouse’s consent. I understand that I should consult an attorney or tax advisor before designating any beneficiaries. I certify that this beneficiary designation satisfies all legal requirements under applicable law. On behalf of myself, the designated beneficiary(ies), my heirs and my estate, I hereby indemnify the Custodian of my HSA, its agents or affiliates harmless from and against any and all claims, damages, liabilities and costs (including attorney’s fees) arising as a result of the Custodian’s payment of my HSA funds under the terms of this Beneficiary Designation.

First Name:	Middle Name:	Last Name:	Social Security Number: <i>(Only Last 4 Digits Required)</i>
Account Holder Signature:			Date:

STEP 5: Spousal Consent (if applicable)

If you designate a beneficiary other than or in addition to your spouse, certain state laws may require your spouse to consent to that beneficiary designation. Consult your attorney or tax advisor for further information.

I certify that I am the spouse of the above-referenced Account Holder. I hereby consent to the designation of beneficiary(ies) as identified above. I relinquish any interest I may have in the HSA funds in accordance with the above-named beneficiary designation.

First Name of Spouse: <i>(Printed)</i>	Last Name of Spouse: <i>(Printed)</i>
Signature of Spouse:	Date:

How to Submit: Please mail the completed, notarized form to:
ConnectYourCare, PO BOX 85960, 6300 Wayne Road, Westland, MI 48185





STEP 6: Confirm Account Holder Information for Notarization

First Name:	Middle Name:	Last Name:
Social Security Number: (Only Last 4 Digits Required)		
X X X / X X / _ _ _ _		

Notary Information

This area is reserved for notarization.

