HSA Distribution Request Form

Attn: Flexible Benefits
PO Box 91110
Sioux Falls, SD 57109
(877) 737-7730
Fax: (605) 328-7207
sanfordhealthplan.com

Accountholder Information

Last name:	First Name:	MI:
Social Security #	Employee ID and Employer:	

I direct TPA to make a distribution from my HSA for the following reason (choose only one reason per form):

Normal/Disability/Prohibited Transaction Distribution

☐ Normal – For payment of qualified medical expenses; save your receipts

☐ Disability – If the disability renders you unable to engage in any substantial gainful activity and it is medically determined that the conditional will last continuously for at least 12 months or lead to your death. Disability distributions are subject to ordinary income tax.

☐ Prohibited Transaction – use of HSA funds for anything other than a qualified medical expense; if not corrected in a timely manner, IRS penalties may be imposed

Amount of Distribution: $________________________________

☐ This transaction will close my account.

Excess Contribution Removal

☐ Excess Contribution Removal:

Amount of excess contribution: $_______________________ Date excess contribution occurred: ___________________________

Rollover/Transfer/Close Account

☐ Rollover – Check will be made payable to HSA Accountholder and mailed to your address on file.

☐ Please liquidate: ☐ My entire account balance ☐ Only this amount $_________________

☐ This transaction will close my account

☐ Transfer – Check will be made payable to the receiving administrator/ trustee/ custodian for the benefit of the HSA Accountholder and mailed to the address you provide below.

Name of receiving administrator/ trustee/ custodian: ____

Address of Receiving administrator/ trustee/custodian: ____

☐ Please liquidate: ☐ My entire account balance ☐ Only this amount $_________________

☐ This transaction will close my account

(Note: If I am requesting account closure, I authorize the TPA to liquidate the investments in my HSA Investment Account and wait 10 days to allow any outstanding debit card transaction to settle before mailing the check for any remaining account balance, less any applicable account closing fee. The IRS Code limits the number of rollovers that may be taken, how quickly rollovers must be completed and how the trustee or custodian must report the transaction. If you need additional information, please contact your tax advisor. By selecting this option, you are certifying to the bank that you have satisfied the rules and conditions applicable to your rollover and that you are making an irrevocable election to treat the transaction as a rollover. The funds you receive from the distribution of an HSA must be deposited into another HSA within 60 days from when you receive them. You are entitled to one distribution per year per HSA which may be rolled over. You are entitled to roll over the same assets only once in a 12 month period.)

Signature

I certify that I am the HSA Accountholder or an individual authorized to execute this transaction. I have read and understand the instructions and any rules or conditions relating to this transaction. I assume full responsibility for this transaction and will not hold Sanford Health Plan or Healthcare Bank, a division of Bell State Bank & Trust liable for any adverse consequences that may result. I have not received tax or legal advice from Sanford Health Plan or Healthcare Bank and, if necessary, will seek the advice of a tax or legal professional to ensure my compliance with related laws. All information provided by me is true and correct and may be relied upon Sanford Health Plan and Healthcare Bank.

____ ____

Signature of accountholder Date