HSA - Account Information Change 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 Initial Personal Information:

First Name		MI		Last Name			
Account #		Social Security #	- -			DOB (mm/dd/yyyy)	/ /

Amendment Type: This is an amendment to an existing HSA due to: (Check all that apply.)

- ☐ Changing my name due to marriage or legal decree (see section A)
- ☐ Changing my phone numbers, mailing address and/or email address (see section A)
- ☐ Adding an authorized signer (see section C)
- ☐ Changing the authorized signer's name due to marriage or legal decree (see section C)
- ☐ Revoking/removing authorized signer (see section D)
- ☐ Designation of beneficiary (see section E)

Section A: Account Holder New Personal Information

First Name		MI		Last Name	
Email					
Home Phone	- -			Business Phone	- -

Change of Address

Previous Address		State		Zip Code	
New Address		State		Zip Code	

Section B: Account Options
Complete this section if you want new checks or debit cards ordered at this time. Complete the Authorized Signer section on page 2 for spousal or third party access to your account.

- ☐ Please replace my HSA debit card issued for my account with my name change
- ☐ Please order an HSA debit card
- ☐ Please order 25 duplicate checks and 10 deposit tickets reflecting my name and/or address change
- ☐ Please order 25 duplicate checks and 10 deposit tickets reflecting my authorized signer
- ☐ Please order 25 duplicate checks and 10 deposit tickets reflecting my name change and adding my authorized signer

Section C: Authorized Signer (additional or secondary signer)

If you wish to designate an authorized signer on your account, please complete all of the required fields below. If you are unable to provide all of the required information on your authorized signer, they will not be added to your account. You hereby designate the following individual as an authorized signer on your HSA. By designating an authorized signer on y our account, you authorize the person designated below as "authorized signer" to transact business with and give instructions to Avidia Bank regarding your HSA; make deposits or withdrawals by any means acceptable to Avidia Bank, including paper and electronic methods such as ACH and Internet generated transactions; receive and have access to account information, including balances and transactions; endorse any instruments such as checks, orders or other documents for the payment of funds; and to otherwise serve as agent for your Avidia Bank HSA.

You specifically authorize Avidia Bank, as custodian of your HSA, to rely upon this authorization and designation until such time, if any, that Avidia Bank receives a written revocation of this authorization, and has had a reasonable time to act upon the revocation. You understand that you are responsible for ensuring that your authorized signer reads and understands Avidia Bank account documents which have been provided to you. You hold harmless and indemnify Avidia Bank against any claims against or losses Avidia Bank may suffer arising out of Avidia Bank's reliance on this authorization, and release Avidia Bank from any liability arising from such reliance, unless otherwise prohibited by law. You understand that you bear sole responsibility for any tax consequences that result from any actions taken by the authorized signer regarding your account.

NO PRESENT OR FUTURE OWNERSHIP OR RIGHT OF SURVIVORSHIP IS GIVEN TO THE AUTHORIZED SIGNER BY THIS AUTHORIZATION. UPON NOTICE TO AVIDIA BANK OF YOUR DEATH, THIS AUTHORIZATION TERMINATES, AND RIGHTS TO FUNDS IN YOUR ACCOUNT WILL BE TRANSFERRED TO YOUR BENEFICIARIES. IF YOU DID NOT NAME A BENEFICIARY, YOUR ACCOUNT WILL ONLY BE PAYABLE TO YOUR ESTATE.

Authorized Signer Personal Information: ALL FIELDS REQUIRED (P.O. BOX NOT ACCEPTED)

Previous First Name		MI		Previous Last Name	
Current First Name		MI		Current Last Name	
Social Security #	- -			DOB (mm/dd/yyyy)	/ /

Drivers License #		License State		Issue Date	
Expiration Date					
Street Address		City			
State		Zip Code		Home Phone	- -

Section D: Revoke Authorized Signer

Authorized Signer To Be Removed From Account:

Authorized Signer First Name		MI		Authorized Signer Last Name	

Please complete one of the sections below.

☐ **Revoked By Account holder** *NOTE: If a debit card has been issued to the authorized signer, it will be deactivated.* The authorized signer authority previously granted to the authorized signer listed above is hereby terminated. I understand that I am responsible for recovering any checks or debit cards which are in the possession of the authorized signer.

☐ **Revoked By Authorized Signer** As authorized signer I understand that I am responsible for returning any checks or debit cards which are in my possession to the account holder.

Section E: Designation of Beneficiary: This information *replaces* all previous beneficiary information

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 hers 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 proper 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.

☐ 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 chose to designate a primary beneficiary other than my spouse, I am responsible for obtaining her consent if required by law

Signature:

I certify that the information provided above and attached hereto is accurate and request that any information provided previously be updated with the information here.

Account Holder Signature____Date____________________

To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. What this means to you: When you open an account we will need you and your authorized signer to provide name, street address, date of birth and other information that will allow us to identify you and your authorized signer. We may also ask to see your driver's license or other identifying documents.