



CONSUMER DRIVEN HEALTHCARE

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)

Form with fields for First Name, MI, Last Name, Social Security #, Account #, and DOB.

Authorized Signer Information: (P.O. Box not accepted)

Since regulations require that only one individual own a Health Savings Account (HSA), the account holder may want his/her spouse and/or third party to be an authorized signer to write checks or use his/her debit card. Note: Authorized signers must be 18 years or older

I (account holder), as named above, designate the following individual as an additional authorized signer on my Health Savings Account.

Form with fields for Authorized Signer Name, MI, Social Security #, DOB, Driver License #, License State, Issue Date, Expiration Date, Street Address, City, State, Zip Code, and Home Phone.

This is the first authorized signer request submitted for my account. Please send a complimentary HSA Card to the individual listed above

I would like to order 25 duplicate checks and 10 deposit tickets with my authorized signer's name.

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 on an account. What this means to you: When you add an authorized signer to your account we will need you to provide your authorized signer's name, street address, date of birth and other information that will allow us to identify your authorized signer.

Signatures

If you wish to designate an authorized signer on your account, please complete all of the required fields listed above. 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 Health Savings Account (HSA).

Owner \_\_\_\_\_ Date \_\_\_\_\_



The balance in your HSA is insured by the Federal Deposit Insurance Corporation (FDIC), and subject to applicable deposit limits.

