



CONSUMER DRIVEN HEALTHCARE

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)

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

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.

Table with 6 columns: Name & Address of Individual, Date of Birth, Social Security#, 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.

CURRENT MARITAL STATUS

- Checkboxes for 'I am not married' and 'I am married' with explanatory text.

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 _____