nyhart

HSA DISTRIBUTION REQUEST FORM

INSTRUCTIONS

1. Use this form to request a distribution from your HSA for one of the reasons indicated below. **For death distributions, complete the Death Distribution Form.**
2. Fax the completed form to 888-887-9961 or forward it to: Nyhart, 8415 Allison Pointe Blvd, Suite 300, Indianapolis, IN 46250.
3. If you have any questions regarding distributions from your HSA, please call 1-800-284-8412.

ACCOUNTHOLDER INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Social Security Number: _____ Employee ID and Employer: _____
(if applicable)

Address: _____ Phone #: _____

I direct Nyhart 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. (Check Fee: $10.00, Direct Deposit: Free)

☐ **Disability -** If the disability renders you unable to engage in any substantial gainful activity and it is medically determined that the condition-al 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: $ _____ ☐ I would like this distribution to close my HSA also.

EXCESS CONTRIBUTION REMOVAL

☐ Excess Contribution Removal

Amount of Excess Contribution: $ _____ Date excess contribution occured: _____

ROLLOVER/TRANSFER

If I am requesting account closure, I authorize the Nyhart to liquidate the investments in my HSA Investment Account and wait 10 days to allow any outstanding debit card transaction (if debit card is applicable to my account) to settle before mailing the check for any remaining account balance, less any applicable account closing fee.

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

Please liquidate ☐ my entire account balance **or** ☐ **$** _____

This rollover ☐ will ☐ will not close my HSA Account (please check one).

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 twelve (12)month period.

☐ **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. It is the HSA Accountholder's responsibility to forward the check to the new Administrator/ Trustee/Custodian.

Please liquidate ☐ my entire account balance **or** ☐ **$** _____

This transfer ☐ will ☐ will not close my HSA Account (please check one).

Name of Receiving Administrator/Trustee/Custodian: _____

Address of Receiving Administrator/Trustee/Custodian: _____

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 Nyhart or Healthcare Bank liable for any adverse consequences that may result. I have not received tax or legal advice from Nyhart 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 Nyhart and Healthcare Bank.

Signature of HSA Accountholder: _____ Date: _____