



CHOICE FINANCIAL

Your HSA Bank.

Withdrawal Request/Distribution Form

Account Holder Information:

Distributions from a Health Savings Account not used for the purpose of paying qualified medical expense may be subject to IRS penalties and income tax. Please consult a tax advisor regarding your individual account and situation.

Name: _____ Social Security Number: _____
 HSA Account Number: _____ Telephone Number: _____ Amount of Withdrawal: _____

Choose One of the Following:

Withdrawal/Distribution for reimbursement to myself. (I paid for a medical expense and I'm requesting reimbursement for the expense.)

Withdrawal/Distribution for a direct payment to a Provider. (Note: If the check is going to a provider, you must provide the patient(s) name and daytime phone number.)

Patient Name: _____ Provider Phone Number: _____

Make Check Payable To:

Name: _____ Address: _____
 City: _____ State: _____ Zip Code: _____

Signature (Account Holder must sign):

I certify the accuracy of the distribution reason selected above and authorize the transaction. I understand that I am responsible for any consequences resulting from this distribution, including any taxes and penalties owed.

X _____
 Account Holder Signature Date

SUBMIT COMPLETED FORM TO ONE OF THE FOLLOWING:

FAX
 701.356.6460
 Attn: HSA Department

MAIL
 Choice Financial - HSA Dept.
 4501 23rd Ave. S.
 Fargo, ND 58104

EMAIL
 hsa@choicefinancialgroup.com
We recommend sending in a secure format.

For customer service, please call our HSA Helpline at: 866.702.9033