



HSA/Blend Claim Form

Account Holder Information

Account Holder Name:			Account Number or Social Security Number:	
Address:			Daytime Phone Number:	
City:	State:	Zip:	<input type="checkbox"/> New Address <input type="checkbox"/> New Phone Number	<input type="checkbox"/> New Email
Employer:			E-mail (Opt.):	

Reason for Withdrawal (check one) and Disbursement Instructions

Please select only ONE of the following options:

- Reimbursement Request ONLY
 Debit Card Substantiation/Receipts
 Pull against Claims Vault
 Please enter my receipts in the Claims Vault – NO reimbursement requested
 This is an HRA Claim

<input type="checkbox"/> Non-Qualified Withdrawal – No documentation attached. I understand I am responsible for all applicable taxes & penalty fees. <input type="checkbox"/> Close Account and Distribute Remaining Balance Requested HSA Withdrawal Amount: \$ _____ <input type="checkbox"/> Deposit into my personal bank account on file. <input type="checkbox"/> Mail check to me (a fee of \$1.50 for each check will apply)	<p>***Please note: ONLY HRA funds can be paid to a Provider***</p> <input type="checkbox"/> Mail Payment to Provider – You must include Provider Account # & Address Provider Name & Account # _____ Provider Mailing Address: _____ _____
<input type="checkbox"/> New Account or Change of Bank Account: Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings Routing #: _____ Bank Name: _____ Account #: _____	

Expense Detail

If this distribution from your HSA is for a Qualified Medical Expense and you want your Plan Service Provider to Certify that the expenses are qualified for tax filing purposes, then please supply medical expense information below. Use a copy of this form if you need more space.

Receipt Attached	Date of Service	Patient Name	Relationship	Provider	Description of Service	Amount
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>	Continued on the Next Page					Claims Submission Total:

Account Holder's Certification for Disbursement

I certify that this distribution requested from my accounts was incurred by me (and/or my spouse and/or eligible dependents), was not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible Section 213(d) medical expenses and should be treated as a Tax-Free Distribution under my HSA. I will not use the expense reimbursed through this account as deductions or credits when filing my individual income tax return. Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Account Holder's Signature: _____ Date: ____/____/____