Health Savings Account (HSA) Distribution Request Form Instructions

PLEASE READ THIS BEFORE SUBMITTING THE FORM

Better, Easier Ways to Get Reimbursed for Healthcare Expenditures

- **Debit Card -** Using your HSA debit card is a safer, faster method of payment, providing you the ability to purchase qualified medical expenses at all merchants that accept Visa Debit Card®.

- **ATM –** Convenient and Fast. You may withdraw funds from any ATM to cover your out-of-pocket medical expenses.

- **Wells Fargo Store –** You may withdraw funds at any Wells Fargo store.

Your HSA distribution request is important to us. To ensure timely processing of your request, please follow the instructions and guidelines below while filling out this form.

Tips for Completing the Distribution Request Form

- Complete all required fields.
- Remember to include your Health Savings Account Number, which can be found on your monthly statement
- Make sure the total distribution amount is accurate.
- Sign and date the form.

Helpful Information

- Your request will not be processed unless the total amount requested is available in your account in cash.

- You may need to transfer investments to cash to cover the amount requested. To do so, please sign on to Health Account Manager℠ at wellsfargo.com/hsa or call the Customer Service Center at 866-884-7374.

- Do not use this form to request a return of excess contributions. The *HSA Distribution Request for Excess Contributions* form is accessible by signing on to Health Account Manager at wellsfargo.com/hsa.

- You may fax this form to 888-824-3868 or mail to *Wells Fargo Health Benefit Services, P.O. Box 45600, Salt Lake City, UT 84145-0600*. If you have any questions, please contact our Customer Service Center at 866-884-7374.

For Your Records

You may use the optional worksheet below to calculate the total amount for your distribution. This worksheet is provided for your convenience and is not required to process your distribution.

Amount	Date	Amount	Date
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	
		TOTAL	**$**

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Health Savings Account (HSA) Distribution Request Form

Account Information * required field		
First Name*	Middle Name	Last Name*
Account Number (10 digit number)*		Social Security Number (last four digits) *
Phone* XXX-XXX-XXXX	Alternate Phone XXX-XXX-XXXX	Email

Distribution Method

How would you like to receive your distribution?

☐ A check sent to my address on record

Credit to a bank account requires the completion of the information below. If left blank a check will be issued.*

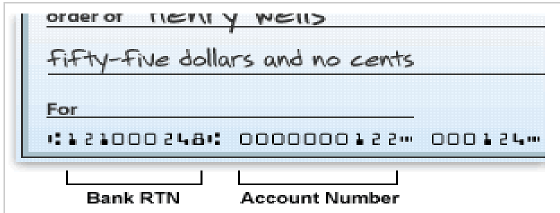
☐ A credit to my Checking Account (If selected, please fill out the account information below)

☐ A credit to my Savings Account (If selected, please fill out the account information below)

Account Number* ______________________________

Routing Number (RTN)*______________________________

Financial Institution Name* ______________________________



Distribution Request Total Amount $ ____________________

I hereby request distribution of the amount listed above from my HSA. By choosing to have my distribution proceeds credited to my bank account referenced above, I authorize Wells Fargo Health Benefit Services (HBS), a division of Wells Fargo Bank, N.A., to credit my bank account and to debit my HSA in the amount stated above, and in accordance with any other instructions, terms or conditions concurrently disclosed to me. I acknowledge that the origination of ACH transactions from my HSA must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until I notify Wells Fargo HBS of its termination by calling 1-866-995-0986 in such a time and manner as to afford Wells Fargo HBS and the depository financial institution a reasonable opportunity to act on it.

I further understand that I am responsible for determining whether or not the distribution from my HSA is used for the payment of qualified medical expenses and therefore qualifies for favorable tax treatment. I understand that my request will not be processed unless the total amount requested is available in my account. I further understand that I should retain supporting documentation for any expenses that I pay for using my HSA distribution in case the Internal Revenue Service conducts an audit on my HSA. In addition, I understand that, if the reimbursements for the expenses listed above are not for qualified medical expenses, I may be subject to income tax and/or penalties.

Signature	**Date (MM/DD/YYYY)**

Fax completed form to 888-824-3868 or mail to:
Wells Fargo Health Benefit Services, P.O. Box 45600, Salt Lake City, UT 84145-0600
Questions? Please contact our Customer Service Center at 866-884-7374.
Web site: wellsfargo.com/hsa

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