Health Savings Account Information Form

Name: _____

Address: _____ City: _____ State/ Zip: _____

Home/ Cell Number: ( ) _____ Work Number: _____

Social Security Number: _____ Date of Birth: _____

Driver's License Number: _____ Issue Date: _____ Exp Date: _____

Employer: _____ Position: _____

Account Type: ☐ Individual ☐ Family

If this is a family account, please complete the following information for the additional person (if they will be a signer on the account):

Name: _____

Address: _____ City: _____ State/ Zip: _____

Home/ Cell Number: ( ) _____ Work Number: _____

Social Security Number: _____ Date of Birth: _____

Driver's License Number: _____ Issue Date: _____ Exp Date: _____

Employer: _____ Position: _____

Would you like a debit card(s) for this account? Yes ☐ No ☐ (owner only?)

Please list the following information for the beneficiary for the account:

Primary Beneficiary:

Percentage	Name of Beneficiary	SSN	Date of Birth	Relationship to HSA Owner
%				
%				
%				

Total 100%

Contingent Beneficiary:

Percentage	Name of Beneficiary	SSN	Date of Birth	Relationship to HSA Owner
%				
%				
%				
%				

Total 100%