HEALTH SAVINGS ACCOUNT DISTRIBUTION REQUEST FORM

Surency FLEX

Use this form to request a distribution from your HSA for one of the reasons indicated below.
Additional information is available by logging into your Member Account at Surency.com

Accountholder Information

Employer Name _____ Employee ID Number _____ Social Security Number _____

Accountholder Name (Last, First, Middle Initial) _____ Phone Number _____ Email Address *(required)* _____

Mailing Address _____ City _____ State _____ ZIP _____

Home Address *(if different)* _____ City _____ State _____ ZIP _____

Distribution Information

Request Amount $: _____

Type of Payment: If you *are not* currently enrolled in Direct Deposit with Surency Flex, you will receive a check (fee of $2.50 will be charged).

If you *are* currently enrolled in Direct Deposit wth Surency Flex, funds will be directly debited into your account. (You can sign up for Direct Deposit within your Member Account at Surency.com or via the Surency Flex mobile app.)

Select one of the following:

- ☐ **Normal -** For payments of qualified medical expenses. Save your receipts.
- ☐ **Disability -** If the disability renders you unable to engage in any substantial gainful activity and it is medically determined that the condition will last continuously for at least 12 months or lead to 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.
- ☐ **Excess Contribution Removal -** Amount of excess contribution $: _____ Date excess contribution occurred: _____
- ☐ **Rollover to Accountholder -** Check will be made payable to HSA Accountholder and mailed to your address on file. NOTE: IRS 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-month period.
- ☐ **Transfer to Custodian -** Transfer Check Payable to: _____
  Mail Check to: _____
- ☐ **Repay FSA -** Distribution from my HSA that will repay expense(s) from my Surency Flexible Spending Account (FSA).

Will this close your HSA?

- ☐ **Close HSA** - By checking this box I understand that my available balance, less a $25.00 fee, will be distributed.
- ☐ **No, this will not close my HSA.**

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 Surency or WEX Inc. liable for any adverse consequences that may result. I have not received tax or legal advice from Surency or WEX Inc. 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 Surency and WEX Inc.

Signature of HSA Accountholder _____ Date _____

Return completed form back to Surency at email: flex@surency.com - fax: 316-272-4841
or mail: P.O. Box 789773, Wichita, KS 67278-9773

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