Surency FLEX

HEALTH SAVINGS ACCOUNT POWER OF ATTORNEY FORM

Member Information

Last Name _____ First Name _____ Middle Initial _____

Social Security Number _____ Emplyee ID & Employer (if applicable) _____

Power of Attorney Designation

Last Name _____ First Name _____ Middle Initial _____

Address _____ City, State & ZIP _____

Social Security Number _____ Telephone Number _____ Date of Birth _____

Surency and Healthcare Bank are hereby authorized to recognize the signature subscribed below in the payment of funds or transactions of any business for this account. All transactions shall be governed by applicable laws and the Health Savings Account Custodial Agreement and Disclosure Statement. To the extent allowed by law, this authorization shall survive my disability or incapacity, and shall remain in effect until Surency receives written notice of revocation and a reasonable oppurtunity to act on such notice.

Signature (must be notarized)

By signing below, I authorize the attorney-in-fact identified above to perform any act I may perform pursuant to my Health Savings Account Custodial Agreement and Disclosure Statement with Surency and Healthcare Bank. This Power of Attorney is effective upon my signing. This authorization includes, for example, the ability to: (1) endorse, cash, or deposit checks or other items payable to my order; (2) withdraw funds from this account via any means allowed for this account (including, but not limited to, checks, debit cards, wire transfers, ect.); and (3) give instructions for the handling of any and all matters in connection with this account. I understand the powers I give to my attorney-in-fact, and any limitations on those powers are between the attorney-in-fact and me, even if Surency and Healthcare Bank have express written notice of those powers. I agree to hold Surency and Healthcare Bank harmless and be responsible for any damages or costs Surency and Healthcare Bank and to Surency and Healthcare Bank's reliance on this Power of Attorney.

Signature of HSA Accountholder _____ Date _____

Subscribed and sworn to before me this

_____day of_____, 20 _____

Signature of Attorney-in-Fact _____ Date _____

_____

Notary Public

Revocation of Power of Attorney (complete only to revoke a prior Power of Attorney designation)

I hereby revoke the appointment of the prior designated Power of Attorney and have notified them of this change. I understand that Surency and Healthcare Bank may charge the account for the amount of any check or pre-authorized transactions dated on or before this date if they have been authorized by my attorney-in-fact.

Signature of HSA Accountholder _____ Date _____

Subscribed and sworn to before me this

_____day of_____, 20 _____

Signature of Attorney-in-Fact _____ Date _____

_____

Notary Public

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

866-818-8805 | Surency.com