

HSA Today™ Expense Detail and Request for Distribution

Account Holder Information

Name of Account Owner:		HSA Account Number:	
Address:		Social Security Number:	
City:		Daytime Phone Number:	
State:	Zip:	Date of Birth:	
Employer:		Date of Death (if applicable):	

- Check One:**
- Please enter my receipts in the claims vault. No reimbursement requested. Complete 1, ONLY.
 - Please enter my receipts in the claims vault. Yes, reimbursement requested. Complete 1 and 2.
 - Reimbursement ONLY, No claims to submit for claims vault at this time. Complete 2, ONLY.
 - Send Refund to my Employer.

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"/>						
					Total	

Reason for Distribution (check one) and Payment Instructions

<input type="checkbox"/> Normal Qualified Distribution <input type="checkbox"/> Non-Qualified Distribution <input type="checkbox"/> Disability <input type="checkbox"/> Withdraw Contribution and send to my Employer	<input type="checkbox"/> Withdrawal Excess Contributions & Earnings for Tax Year _____ <input type="checkbox"/> Close Account and Distribute Remaining Balance <input type="checkbox"/> Death <input type="checkbox"/> Other _____
Requested HSA Withdrawal: \$ _____ <input type="checkbox"/> Mail check to me (a fee of \$1.50 for each check will apply) <input type="checkbox"/> Deposit into my personal bank account on file. <input type="checkbox"/> New Account or Change Account:	Route #: _____ Account #: _____ Bank Name: _____ Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings
<input type="checkbox"/> NO Expense Detail <input type="checkbox"/> New Expense Detail	

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.

HSA Owner's Signature: _____ **Date:** ____/____/____

Send Request for Disbursements:

Fax to: PSP Fax Number

Mail to: PSP Mailing Address