



Health Savings Account Distribution Request Form

HSA Owner Information:

Company Name _____

Account Owner Name _____ Social Security Number _____

Address _____

City _____ State _____ Zip _____

Phone (_____) _____ Email _____

Distribution Information:

(Please select one) Spender Saver

Normal distribution Disability Death

Amount of requested distribution \$ _____

Date of distribution request ____/____/____

I hereby authorize the Custodian and Record Keeper to perform the above transaction on behalf of my HSA. I certify that all information provided by me is true and accurate. I understand that I am responsible for any consequences resulting from this transaction, including any imposed tax and/or penalties. I agree that the Custodian and Record Keeper shall in no way be held responsible. I further certify that I have not received any tax or legal advice from the Custodian or Record Keeper.

Signature of HSA Owner

Date

Submitting Distribution Request:

Please mail completed Distribution Request Form to:

Alliance Benefit Group
Attn: HSA Department
PO Box 1226
Albert Lea, MN 56007

Or fax completed Distribution Request Form to: 1.866.254.6490

Note: The minimum distribution amount is **\$25.00**. Incomplete request forms will be returned unprocessed. Please do not include receipts or statements for medical expenses with your request form.