

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:

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. Should the balance of my HSA be invested in more than one of the available investment options, I understand that funds for this payment will be distributed from all applicable investments on a pro-rata basis by investment balance.

Signature of HSA Owner

Date

Submit this request to ABG at:

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

1-866-808-7823 (toll-free fax) hsa@abg-mn.com

Online Claims: You also have the option to request your HSA distribution online at www.myabg.com. It is not necessary to complete this form when requesting your distribution online.

Note: The minimum distribution amount is **\$5.00**. Incomplete request forms will be returned unprocessed. Please do not include receipts or statements for medical expenses with your request form.