

Instructions:

- Use this form to change an existing/already established Health Savings Account (HSA).
- Complete this form and mail or fax it to: **HSA Bank, P.O. Box 939, Sheboygan, WI 53082, FAX (877) 851-7041.**
- For assistance, call (877) 924-3967

ACCOUNTHOLDER INITIAL PERSONAL INFORMATION

First Name:	MI:	Last name:
Account Number:	Social Security Number:	Date of Birth: (mm/dd/yyyy)

AMENDMENT TYPE

This is an amendment to an existing HSA due to: (Check all that apply.)

- Changing my name due to marriage or legal decree (see section A)
(Note: Please include one of the following supporting documents: marriage license, divorce decree, Certificate of Naturalization showing a new name, or a court order for the name change.)
- Adding an authorized signer (see section B)
- Changing the authorized signer's name due to marriage or legal decree (see section B)
- Revoking/removing authorized signer (see section C)

SECTION A: ACCOUNTHOLDER NEW PERSONAL INFORMATION

First Name:	MI:	Last Name:
To update your mailing address, please log into your account at www.wageworks.com		

SECTION B: AUTHORIZED SIGNER (ADDITIONAL OR SECONDARY SIGNER)

If you wish to designate an authorized signer on your account, please complete all of the required fields below. If you are unable to provide all of the required information on your authorized signer, they will not be added to your account. You hereby designate the following individual as an authorized signer on your HSA. By designating an authorized signer on your account, you authorize the person designated below as "authorized signer" to transact business with and give instructions to HSA Bank regarding your HSA; make deposits or withdrawals by any means acceptable to HSA Bank, including paper and electronic methods such as ACH and Internet-generated transactions; receive and have access to account information, including account balances and transactions; endorse any instruments such as checks, orders or other documents for the payment of funds; and to otherwise serve as agent for your HSA Bank HSA.

You specifically authorize HSA Bank, as custodian of your HSA, to rely upon this authorization and designation until such time, if any, that HSA Bank receives a written revocation of this authorization, and has had a reasonable time to act upon the revocation. You understand that you are responsible for ensuring that your authorized signer reads and understands the HSA Bank account documents which have been provided to you.

You hold harmless and indemnify HSA Bank against any claims against or losses HSA Bank may suffer arising out of HSA Bank's reliance on this authorization, and release HSA Bank from any liability arising from such reliance, unless otherwise prohibited by law. You understand that you bear sole responsibility for any tax consequences that result from any actions taken by the authorized signer regarding your account.

NO PRESENT OR FUTURE OWNERSHIP OR RIGHT OF SURVIVORSHIP IS GIVEN TO THE AUTHORIZED SIGNER BY THIS AUTHORIZATION. UPON NOTICE TO HSA BANK OF YOUR DEATH, THIS AUTHORIZATION TERMINATES, AND RIGHTS TO FUNDS IN YOUR ACCOUNT WILL BE TRANSFERRED TO YOUR BENEFICIARIES. IF YOU DID NOT NAME A BENEFICIARY, YOUR ACCOUNT BALANCE WILL ONLY BE PAYABLE TO YOUR ESTATE.

AUTHORIZED SIGNER PERSONAL INFORMATION:

All fields required. P.O. Box not accepted.

Previous First Name:	MI:	Previous Last Name:	
Current First Name:	MI:	Current Last Name:	
Social Security Number:	Date of Birth: (mm/dd/yyyy)	Home Phone Number:	
Street Address:			
City:	State:	Zip Code:	

SECTION C: REVOKE AUTHORIZED SIGNER

Authorized signer to be removed from account:

Authorized Signer First Name:	MI:	Authorized Signer Last Name:
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Please complete one of the selections below.

Revoked by Accountholder

The authorized signer authority previously granted to the authorized signer listed above is hereby terminated.

 Accountholder Signature Date

Revoked by Authorized Signer

 Authorized Signer Signature Date