HealthEquity

Health Savings Account
Beneficiary Designation Form

Personal Information

Name: First: _____ Last: _____ Middle: _____

Social Security Number: _____ HealthEquity Account Number: _____

Beneficiary(s)

Please designate the beneficiary(s) for your Health Savings Account who will receive the balance in your account upon your death.

First Name: _____ Last Name: _____ Relationship: _____ Percentage _____%
Address: _____ City:_____ State:_____ Zip Code _____

First Name: _____ Last Name: _____ Relationship: _____ Percentage _____%
Address: _____ City:_____ State:_____ Zip Code _____

First Name: _____ Last Name: _____ Relationship: _____ Percentage _____%
Address: _____ City:_____ State:_____ Zip Code _____

First Name: _____ Last Name: _____ Relationship: _____ Percentage _____%
Address: _____ City:_____ State:_____ Zip Code _____

Total 100%

Authorization of Spouse

Spousal Consent
This section should be reviewed if the member is married and a resident of a community or marital property state. Due to important tax and legal consequences of giving up a community property interest, individuals signing this section should consult with an independent legal or tax advisor.

Current Marital Status
□ I am not married—I understand that if I become married in the future, I must complete a new Beneficiary Designation form.
□ I am married—I understand that if I choose to designate a primary beneficiary other than my spouse, my spouse must sign below.

I am the spouse of the above-named member. I acknowledge that I have received a fair and reasonable disclosure of my spouse's property and financial obligations. Due to the important tax consequences of giving up my interest in this account, I have been advised to see a tax professional. I hereby give the accountholder any interest I have in the funds or property deposited in this account and consent to the beneficiary designation indicated above. I assume full responsibility for any adverse consequences that may result. No tax or legal advice was given to me by HealthEquity.

_____ _____
Signature of Spouse Date Signature of Witness (Required—Cannot be Spouse) Date

HSA Client Signature

_____ _____ _____
Print Name Signature Date

Please Mail or Fax Completed Forms to:
HealthEquity Enrollment
15 West Scenic Pointe Drive, Suite 400
Draper, UT 84020
Fax: 520-844-7090