

Health Savings Account (HSA) Designation/Change of Beneficiary



Mail completed, signed, and (if applicable) notarized form to:

Wells Fargo Health Benefit Services, P.O. Box 413042, Salt Lake City, UT 84141-3042

This Designation/Change of Beneficiary is subject to the provisions herein, which should be read carefully before completing this form.

HSA Owner's Name		Social Security Number	
Current Home Address	City	State	Zip Code
Current Employer Name	Current Health Insurance Carrier / Insurance Provider		

I hereby revoke any Designation of Beneficiary I may previously have made with respect to the above HSA and designate the following as my Beneficiary(ies):

Primary Beneficiary #1 First and Last Name*	Share (%)	Date of Birth (mm/dd/yyyy)	Social Security Number	Relationship
Current Home Address of Beneficiary #1		City	State	Zip Code
Primary Beneficiary #2 First and Last Name *	Share (%)	Date of Birth (mm/dd/yyyy)	Social Security Number	Relationship
Current Home Address of Beneficiary #2		City	State	Zip Code
Contingent Beneficiary #1 First and Last Name *	Share (%)	Date of Birth (mm/dd/yyyy)	Social Security Number	Relationship
Current Home Address of Contingent Beneficiary #1		City	State	Zip Code
Contingent Beneficiary #2 First and Last Name *	Share (%)	Date of Birth (mm/dd/yyyy)	Social Security Number	Relationship
Current Home Address of Contingent Beneficiary #2		City	State	Zip Code

Instructions to Account Holder: If you are changing your previous beneficiary election(s), your signature on this form must be notarized below.

State of _____ County of _____

On _____ before me, _____

Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity and that by his/her signature on the instrument the person, or entity upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal

Signature of Notary Public

(seal)

* Required field

I understand that the entire death benefit under the HSA will be paid to the primary beneficiaries who survive me in equal shares (unless different percentages are designated above). If no primary beneficiary survives me, the entire benefit will be paid to the contingent beneficiaries who survive me in equal shares (unless different percentages are designated above). If no primary or contingent beneficiary survives me, the entire death benefit will be paid according to the terms of the *Health Savings Account Trust Agreement for Employees and Individuals* ("Trust Agreement") for this HSA. If a primary or contingent beneficiary does not survive me, such beneficiary's interest shall lapse, and the percentage of any remaining beneficiaries shall be increased on a pro rata basis. If I have designated a Trust as beneficiary, the entire benefit will be paid to the Trust (unless different percentages are designated above). I may change this beneficiary designation at any time without the consent of any person or Trust named as a beneficiary (except as outlined below for marital/community property states). Neither this designation nor any future change of beneficiary will be effective unless filed with Wells Fargo Bank, N.A. before my death. This beneficiary designation and all rights to benefits are governed by the terms of the Trust Agreement for this HSA, as amended from time to time.

x	x
Signature of HSA Owner	Date (mm/dd/yyyy)

Trust Information If you wish to designate one or more trusts as beneficiary(ies) of your HSA, please complete the following section. All fields are required.

Name of Trust #1	Share (%)	Trustee Name	Taxpayer ID Number	Date of Trust	
Current Address of Trustee			City	State	Zip Code
Name of Trust #2	Share (%)	Trustee Name	Taxpayer ID Number	Date of Trust	
Current Address of Trustee			City	State	Zip Code

Instructions to Account Holder: If you are changing your previous beneficiary elections, your signature on this form must be notarized below.

State of _____ County of _____

On _____ before me, _____

Notary Public, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity and that by his/her signature on the instrument the person, or entity upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal

Signature of Notary Public

(seal)

Signature of HSA Owner

Date (mm/dd/yyyy)

Spousal Consent

Instructions to HSA Owner who resides in or establishes an HSA in a community or marital property state and names a beneficiary other than his or her spouse.

It is your responsibility to determine whether spousal consent is necessary. Failure to have your spouse sign below may invalidate your beneficiary designation for a portion of your HSA. Please consult your tax or legal advisor if you have questions about this section.

Spousal Consent

I am the spouse of the HSA Owner named above. I understand that my spouse is naming a beneficiary for the HSA other than myself. I approve and consent to the naming of said beneficiary, and I hereby transmute (transfer) and partition any community property interest I have or would otherwise have in this HSA into the separate property of my spouse for disposition as my spouse sees fit. I understand the consequences of giving up my interest, and acknowledge that I have been advised to seek tax or legal advice regarding these consequences.

Signature of Spouse

Date (mm/dd/yyyy)