

HSA CHANGE OF BENEFICIARY FORM



This HSA Change of Beneficiary Form is used to change the beneficiaries for HSAs. If you have any questions regarding this form, please call Shareholder Services at 1-800-934-5550.

PART I: HSA OWNER INFORMATION

Name* (First, M.I., Last) _____ Date of Birth* _____ Social Security Number* _____

Street Address (Physical Address)* _____ Apartment # _____ City* _____ State* _____ Zip Code* _____

Daytime Phone* _____ Evening Phone _____

PART II: HSA ACCOUNT INFORMATION

HSA Account/Plan Number: _____

NOTE: THIS BENEFICIARY DESIGNATION SUPERCEDES ALL PRIOR DESIGNATIONS FOR THE HSA IDENTIFIED ABOVE.

PART III: BENEFICIARY DESIGNATION

Designate beneficiaries below. If the Primary or Contingent status is not indicated, the individual or entity will be considered a Primary beneficiary. After your death, your HSA assets will be distributed in equal shares (unless indicated otherwise) to the Primary beneficiaries who survive you. If no Primary beneficiaries are living when you die, your HSA assets will be distributed in equal shares (unless otherwise indicated) to the Contingent beneficiaries who survive you. You may revoke or change the beneficiary designation at any time by completing a new *HSA Change of Beneficiary Form* and providing it to the Trustee/Custodian.

Type: Primary Contingent Share Percentage: _____ % Relationship to HSA Owner: spouse non-spouse
Name: _____ Taxpayer ID Number: _____ Date of Birth: _____
Residence Address: _____

Type: Primary Contingent Share Percentage: _____ % Relationship to HSA Owner: spouse non-spouse
Name: _____ Taxpayer ID Number: _____ Date of Birth: _____
Residence Address: _____

Type: Primary Contingent Share Percentage: _____ % Relationship to HSA Owner: spouse non-spouse
Name: _____ Taxpayer ID Number: _____ Date of Birth: _____
Residence Address: _____

PART III: BENEFICIARY DESIGNATION-CONTINUED

Type: Primary Contingent Share Percentage: _____ % Relationship to HSA Owner: spouse non-spouse

Name: _____ Taxpayer ID Number: _____ Date of Birth: _____

Residence Address: _____

Addendum attached and signed for additional beneficiaries.

If you need additional space to name beneficiaries, attach a separate sheet that includes all information requested above and indicates whether the beneficiaries are primary or secondary. Sign and date the sheet. To name a Trust as your beneficiary, attach a copy of the Trust Agreement to this form.

PART IV: SPOUSAL CONSENT

Complete this section only if you, the HSA owner, have your legal residence in a community or marital property state and you wish to name a beneficiary other than or in addition to your spouse as Primary beneficiary. This section may have important tax consequences to you and your spouse so please consult with a competent advisor prior to completing. If not currently married and you marry in the future, you must complete a new beneficiary designation that includes the spousal consent provisions.

CONSENT OF SPOUSE

By signing below, I acknowledge that I am the spouse of the HSA owner and agree with and consent to my spouse's designation of a Primary beneficiary other than, or in addition to, me. I understand that with my consent I transfer my community property interest in this HSA to my spouse as his or her separate property. I have been advised to consult a competent advisor and I assume all responsibility regarding this consent. The Trustee/Custodian has not provided me any legal or tax advice.

Signature of Spouse:

X _____ Date: _____

Witness:

X _____ Date: _____

PART V: ACKNOWLEDGEMENT

By signing this *HSA Change of Beneficiary Form*, I certify that the information I have provided is true, correct, and complete, and the Trustee/Custodian may rely on what I have provided. In addition, I assume all responsibilities for the elections I have made, including those related to naming a non-spouse beneficiary, if I am married. I will indemnify and hold the Trustee/Custodian harmless from any consequences related to executing my directions. I have been advised to seek competent legal and tax advice and have not been provided any such advice from the Trustee/Custodian.

Signature of HSA Owner: X _____ Date _____

PART VI: MAILING INSTRUCTIONS

Please send completed form to:

Regular Mail Delivery
IMS Family of Funds
P.O. Box 6110
Indianapolis, IN 46206-6110

Overnight Delivery
IMS Family of Funds
2960 N. Meridian Street, Suite 300
Indianapolis, IN 46208