


# HSA DISTRIBUTION ORDER

**DEPOSITORY INSTITUTION**  
GATEWAY BANK, F.S.B.  
919 Clement Street  
San Francisco, CA 94118

Submit  
distribution  
orders via mail  
or fax to: 

**PLAN SERVICE PROVIDER**  
BENEFIT ADMINISTRATORS  
1009 Oak Hill Road, Third Floor, Lafayette, CA 94549  
Phone: 888-672-1997 Ext. 8516 • Fax: 925-299-8010

\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|  
Last Four Digits Of S.S. #

## HSA ACCOUNT HOLDER

HSA ACCOUNT HOLDER'S NAME \*(NOT THE BENEFICIARY)

SOCIAL SECURITY NUMBER

ADDRESS

CITY

STATE

ZIP

HOME PHONE \_\_\_\_\_

BUSINESS PHONE \_\_\_\_\_

## HSA DISTRIBUTION TYPE

I direct the Custodian / Plan Service Provider to make a distribution from the above named account for the following reason:

Select One Reason Only Per Distribution Order.

- 1. Qualified Medical Expenses (Keep the your expense records to support this distribution order).
- 2. The account holder is \_\_\_\_\_ years old and eligible for Medicare (as specified in 1811 of the Social Security Act).
- 3. Permanent Disability (as defined within the meaning of section 782(m)(7) of the Internal Revenue Code).
- 4. Death. (If you are a Beneficiary of this account and can furnish a certified copy of the Death Certificate.)
- 5. Prohibited Transaction.
- 6. Removal of Excess Contribution plus earnings before tax filing deadline.  
In which tax year was the contribution(s) were being made for? 200\_\_\_\_  
Is the contribution plus earnings being removed in the same year? \_\_\_ Yes \_\_\_ No
- 7. Removal of Excess Contributions after tax filing deadline.
- 8. Transfer. (Including transfer incident to Divorce or Legal Separation.)
- 9. Rollover. (Account Holder understands the 60 day rollover limitation and other rollover provisions.)
- 10. Non-Qualified, Premature (in that it does not meet any of the above distribution purposes).

## HSA DISTRIBUTION AMOUNT

I instruct the Custodian / Plan Service Provider to distribute from the above account for [Select (1) or (2)]:

- (1) **The Amount Requested** (*Your Typical Selection*)
- (2) **The Entire Account Balance (Your account will be closed)**  
(As determined by Custodian / Plan Service Provider.)

\$ \_\_\_\_\_

(\$25.00 min balance required)

**Please Do Not Make Notes On This Form.**

\*Reason & Amount Distributed (reported to the IRS)

## MODE OF PAYMENT

If no box is selected below, by default distribution will be paid in the form of a check and account holder will be liable for \$5.00 service charge.

- (1) **Distribute funds to Account Holder's Personal Account**  
Please attach copy of voided check, unless currently set up for ACH (Electronic Funds Transfer).
- (2) **Issue check to Account Holder**  
(Subject to a Check Issue Service Charge of \$5)

## SIGNATURE

I certify that I am the proper party to receive payment(s) from this HSA, and that all information provided by me is true and accurate. I further certify that no tax advice has been given to me by the Custodian or Plan Service Provider and that all decisions regarding this withdrawal are my own. I expressly assume the responsibility for any adverse consequences which may arise from this withdrawal and I agree that the Custodian or Plan Service Provider shall in no way be responsible for those consequences.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Allow up to 2 weeks for receipt of funds.*

\*\*\*\*\*PLEASE DO NOT SEND RECEIPTS, STATEMENTS OR EOB'S\*\*\*\*\*