HSA*Today*™ Expense Detail and Request for Distribution

Account Holder Information

Name of Account Owner:		HSA Account Number:	
Address:		Social Security Number:	
City:		Daytime Phone Number:	
State:	Zip:	Date of Birth:	
Employer:		Date of Death (if applicable):	

Check One:
- ☐ **Please enter my receipts in the claims vault. No reimbursement requested. Complete 1, ONLY.**
- ☐ **Please enter my receipts in the claims vault. Yes, reimbursement requested. Complete 1 and 2.**
- ☐ **Reimbursement ONLY, No claims to submit for claims vault at this time. Complete 2, ONLY.**

1 Expense Detail

If this distribution from your HSA is for a Qualified Medical Expense and you want your Plan Service Provider to Certify that the expenses are qualified for tax filing purposes, then please supply medical expense information below. Use a copy of this form if you need more space.

Receipt Attached	Date of Service	Patient Name	Relationship	Provider	Description of Service	Amount
☐						
☐						
☐						
☐						
☐						
					Total	

2 Reason for Distribution (check one) and Payment Instructions

- ☐ Normal Qualified Distribution
- ☐ Non-Qualified Distribution
- ☐ Disability
- ☐ Withdrawal Excess Contributions & Earnings for Tax Year _____
- ☐ Close Account and Distribute Remaining Balance
- ☐ Death
- ☐ Other _____

Requested HSA Withdrawal:

$ _____

- ☐ Mail check to me (a fee of **$1.50** for each check will apply)
- ☐ Deposit into my personal bank account on file.
- ☐ **New** Account or **Change** Account:

Bank Name: _____

Route #: _____

Account #: _____

Account Type: ☐ Checking ☐ Savings

- ☐ NO Expense Detail
- ☐ New Expense Detail

Account Holder's Certification For Disbursement

I certify that this distribution requested from my accounts was incurred by me (and/or my spouse and/or eligible dependents), was not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible Section 213(d) medical expenses and should be treated as a Tax-Free Distribution under my HSA. I will not use the expense reimbursed through this account as deductions or credits when filing my individual income tax return. Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

HSA Owner's Signature: _____ **Date**: _____/_____/_____

Send Request for Disbursements: **Fax to:** 906-863-1105 **Mail to:** PO Box 577 Menominee, MI 49858