Health Savings Account Beneficiary Form

This form allows current Health Savings Account (HSA) enrollees to modify their Beneficiary information.

Instructions

Fill out this form and return to EMPOWER by mail, fax, or email.

EMPOWER
7309 E 21st St N Suite 110
Wichita, KS 67206

Fax: (316) 687-2113

customerservice@empowerflex.com

HSA Account Owner Information

Employer ________________________________ Social Security Number ________________________________

Employee Name ___________________________ Date of Birth _______/_______/________

Beneficiary Information

Please note that all existing Beneficiaries on the account will be removed and replaced with the below Beneficiaries. If you need to add more than two Beneficiaries, please print out as many copies of the form as needed.

Beneficiary 1

Relationship	☐ Spouse ☐ Dependent ☐ Estate ☐ Other		
First Name	______________________	Last Name	______________________
Middle Initial	______________________	Social Security Number	______________________
Date of Birth	_______/_______/________		
Address Line 1	______________________		
Address Line 2	______________________		
City	______________________	State ____________	Zip ______________
Type	☐ Primary ☐ Contingent		
Share Percentage	_______%		

Beneficiary 2

Relationship	☐ Spouse ☐ Dependent ☐ Estate ☐ Other		
First Name	______________________	Last Name	______________________
Middle Initial	______________________	Social Security Number	______________________
Date of Birth	_______/_______/________		
Address Line 1	______________________		
Address Line 2	______________________		
City	______________________	State ____________	Zip ______________
Type	☐ Primary ☐ Contingent		
Share Percentage	_______%		

Signature ____________________________________ Date _______/_______/________