

**Your Information**

Account Number \_\_\_\_\_  
First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

**Old Address**

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**New Address**

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Account holder signature**

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

**Please mail or fax this form to:**

Health Savings Administrators  
10800 Midlothian Turnpike, Suite 240  
Richmond, VA 23235  
Fax: 804-726-1570

**Office Approval**

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