

Health Savings Administrators

10800 Midlothian Turnpike, Suite 240

Richmond, VA 23235

Phone: 888-354-0697 • Fax: 804-355-5375

**Health Savings Account
Change of Beneficiary Form****Your Information**

Social Security # _____ - _____ - _____ Date of Birth ____/____/_____

First Name _____ MI _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Beneficiary Information

Effective immediately, the following individual(s) or entity shall be my primary and/or contingent beneficiary(ies). If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary beneficiary. If more than one primary beneficiary is designated and no distribution percentages are indicated, the beneficiaries will be deemed to own equal share percentages in the account. Multiple contingent beneficiaries with no share percentage indicated will also be deemed to share equally. If primary or contingent beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining beneficiary(ies) shall be increased on a pro-rated basis. If no primary beneficiary(ies) survives me, the contingent beneficiary(ies) shall acquire the designated share of my account.

Name	Relationship	DOB	SSN	Primary or Contingent	% of benefit

Signature

Signature _____ Date ____/____/_____

Please mail or fax this form to:

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