sentinelgroup

# Health Savings Account (HSA)

## Distribution Request Form

**Instructions:**

Complete this form to request a distribution from your HSA only for one of the reasons indicated below. All fields are required. Normal withdrawals should be requested online by logging in to your account at sentinelgroup.com.

**Accountholder Information:**

Participant Name _____ Social Security Number _____ Telephone Number _____

Email Address _____ Name of Employer _____

Street Address _____ City _____ State _____ Zip _____

**Distribution Instructions (select one):**

I direct Sentinel Benefits to make a distribution from my HSA in the form of the following type (select only one type per form):

| | | |
|---|---|---|
| ☐ **Total Distribution to Close Account *** | Use of HSA funds for anything other than a qualified medical expense, if not corrected in a timely manner, may cause IRS penalties to be imposed. | |
| ☐ **Excess Contribution Removal** | Amount of Excess Contribution: | $ |
| | Date excess contribution occurred: | |
| ☐ **Rollover** | ☐ Partial Rollover: $ **or** ☐ Liquidate my entire account balance | |
| | This Rollover ☐ **will** / ☐ **will not** close my existing HSA* | |
| | **Check will be made payable to HSA Accountholder and mailed to your address on file.** IMPORTANT NOTE: The IRS Code limits the number of rollovers that may be taken, how quickly rollovers must be completed and how the trustee or custodian must report the transaction. If you need additional information, please contact your tax advisor. By selecting this option, you are certifying that you have satisfied the rules and conditions applicable to your rollover and that you are making an irrevocable election to treat the transaction as a rollover. The funds you receive from the distribution of an HSA must be deposited into another HSA within 60 days from when you receive them. You are entitled to one distribution per year per HSA which may be rolled over. You are entitled to roll over the same assets only once in a twelve (12) month period. | |
| ☐ **Transfer to New Custodian** | ☐ Partial Transfer: $ **or** ☐ Liquidate my entire account balance | |
| | This Transfer ☐ **will** / ☐ **will not** close my existing HSA* | |
| | Check will be made payable to the receiving Custodian for the benefit of the HSA Accountholder and mailed to the address you provide below. | |
| | Name of Receiving Administrator/Trustee/Custodian: | |
| | Street Address: | |
| | City: | State: ZIP: |

**Authorization:**

I certify that I am the HSA Accountholder, or an individual authorized to execute this transaction. I have read and understand the instructions and any rules or conditions relating to this transaction. I assume full responsibility for this transaction and will not hold Sentinel Benefits or WEX Inc. liable for any adverse consequences that may result. I have not received tax or legal advice from Sentinel Benefits or WEX Inc. and, if necessary, will seek the advice of a tax or legal professional to ensure my compliance with related laws. All information provided by me is true and correct and may be relied upon by Sentinel Benefits and WEX Inc.

*If account closure is requested, I authorize Sentinel Benefits to liquidate the investments in my HSA. Finally, by signing below I am consenting to the $25 account closing fee assessed by Sentinel Benefits Group, LLC.

Signature of HSA Account Holder

Date

| | Email | Mail |
|---|---|---|
| Submit this completed form via one of the following methods: | HSA@sentinelgroup.com | Sentinel Benefits & Financial Group<br>Attn: HSA Department<br>100 Quannapowitt Parkway, P.O. Box 4010<br>Wakefield, MA 01880 |

For questions, please contact Sentinel Benefits at 888-762-6088.