

Beneficiary Designation Form

HealthEquity®

Please mail or fax completed forms to:

Address: HealthEquity, Attn: Member Services
PO Box 14374 Lexington, KY 40512
Fax: 801.727.1005

Complete this information online under “My Profile” in your member portal.

Note: If married, living in a community property state (for example AK, AZ, CA, ID, LA, NV, NM, TX, WA, or WI), and want to designate a primary beneficiary other than your spouse, your spouse must agree in writing to your designation and you must submit a physical copy of this form by mail or fax.

You should consult your legal/tax advisor when completing this form, as there may be tax and/or legal consequences to your designation.

You have the option to list one or more persons to be the primary and contingent beneficiaries for your HSA (including your estate or a trust, as applicable). If designating multiple primary or contingent beneficiaries, indicate the percentage share each should receive, ensuring the total of each adds up to 100%.

Designations are effective upon receipt by HealthEquity and, unless otherwise specified, cancel all previous HSA beneficiary designations on file.

P111-0819

Account Holder Information (all fields are required)

Last Name	First Name	M.I.
E-Mail Address	Daytime Phone ()	SSN or HealthEquity ID Number

Primary Beneficiary(ies)

To ensure timely completion of your request, please complete all fields for each beneficiary you designate.

Primary Beneficiary 1 Estate/Trust ☐ Yes ☐ No

Name	SSN or TIN	Date of Birth (mm/dd/yyyy)
Address	City	State
Relationship	ZIP	Percent %

Primary Beneficiary 2 Estate/Trust ☐ Yes ☐ No

Name	SSN or TIN	Date of Birth (mm/dd/yyyy)
Address	City	State
Relationship	ZIP	Percent %

Primary Beneficiary 3 Estate/Trust ☐ Yes ☐ No

Name	SSN or TIN	Date of Birth (mm/dd/yyyy)
Address	City	State
Relationship	ZIP	Percent %

Primary Beneficiary 4 Estate/Trust ☐ Yes ☐ No

Name	SSN or TIN	Date of Birth (mm/dd/yyyy)
Address	City	State
Relationship	ZIP	Percent %

Contingent Beneficiary(ies)

Contingent beneficiaries receive your HSA assets in the event that all of your primary beneficiaries pass away before you.

Contingent Beneficiary 1 Estate/Trust ☐ Yes ☐ No

Name	SSN or TIN	Date of Birth (mm/dd/yyyy)
Address	City	State
Relationship	ZIP	Percent %

Contingent Beneficiary 2 Estate/Trust ☐ Yes ☐ No

Name	SSN or TIN	Date of Birth (mm/dd/yyyy)
Address	City	State
Relationship	ZIP	Percent %

Total 100%

Authorization

Participant Signature	Name (please print)	Date
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If you're a resident of a community or marital property state and have designated a beneficiary other than, or in addition to, your spouse, have your spouse authorize the designation by signing below.

Spousal Consent: I am the legal spouse of the HSA account holder. I acknowledge that I have received a fair and reasonable disclosure of my spouse's property and financial obligations. Due to the tax consequences of giving up my interest in this HSA, I have been advised to see a qualified tax professional. I hereby consent to the beneficiary designation(s) indicated above.

Spouse's Signature	Name (please print)	Date
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