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 ________________________________ SSN (last four only) ________________________________

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 _______/_______/________