

HEALTH SAVINGS ACCOUNT Beneficiary Designation Form

To designate, revoke, or change a beneficiary, please complete, sign, and date this Beneficiary Designation Form and fax it to American Fidelity to the number above. The designation/revocation/change will be effective as of the date this form is received.

PLEASE NOTE: Do not use a coversheet if faxed. Fax will go into secured inbox. Bar code must be visible on first page for processing.

A. General Information			
Name		SSN	
Address		DOB <small>(mm/dd/yyyy)</small>	
City, State, Zip		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Email address		Day Phone	
Employer Name*		Home Phone	

*If HSA was established separate from your employer, employer name is not needed

B. Beneficiary Information						
Add <input type="checkbox"/> Remove <input type="checkbox"/>	Name		Relationship		<input type="checkbox"/>	Primary
	Address		DOB		<input type="checkbox"/>	Contingent
	City, St, Zip				___%	Percent
Add <input type="checkbox"/> Remove <input type="checkbox"/>	Name		Relationship		<input type="checkbox"/>	Primary
	Address		DOB		<input type="checkbox"/>	Contingent
	City, St, Zip				___%	Percent
Add <input type="checkbox"/> Remove <input type="checkbox"/>	Name		Relationship		<input type="checkbox"/>	Primary
	Address		DOB		<input type="checkbox"/>	Contingent
	City, St, Zip				___%	Percent
Add <input type="checkbox"/> Remove <input type="checkbox"/>	Name		Relationship		<input type="checkbox"/>	Primary
	Address		DOB		<input type="checkbox"/>	Contingent
	City, St, Zip				___%	Percent

By signing this form, I certify that I have read and understand the instructions and that all information I have entered is true and complete. Submission of this document replaces any past designations I have made.

Account Holder's Signature

Date



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