Health Savings Account-HSA

HSA INFORMATION AUTHORIZATION FORM

Instructions

1-This form is used to authorize another individual access to information regarding your HSA.

2-FAX the completed form to the HSA Administrator: **Flexible Benefits System at 585-641-7500**
or **Mail completed form to Flexible Benefits System, Inc.** at: **400 WillowBrook Office Park-Suite 400, Fairport NY 14450.**

3-For questions regarding this form, contact Flexible Benefits System, at **1-800-622-6233.**

Accountholder Information

Last Name	First Name	Middle Initial

Social Security Number	Employee ID and Employer (if applicable)

Authorized Individual Information

I authorize HSA Administrator's customer service representatives to provide information regarding my HSA, including but not limited to the balance and transaction history, to the individual named below.

I understand and agree that:
—the individual named below will **not** be authorized to perform my account maintenance;
—this authorization pertains to information obtained from customer service only; and
—I am the sole individual authorized to access and maintain my account online.

Last Name	First Name	Middle Initial

Telephone	Date of Birth
Street Address	**City, State- ZipCode**

Authorization Signature

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 HSA Administrator or Healthcare Bank, a division of Bell Bank liable for any adverse consequences that may result. I have not received tax or legal advice from HSA Administrator or Healthcare Bank 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 HSA Administrator and Healthcare Bank.

Signature of HSA Accountholder: **Date:**

Office Use Only			