



Health Savings Account (HSA) Account Closure/Withdrawal Request

As Owner of the Health Savings Account identified below, I hereby request that the Custodian take the following action:

Account Closure Request

I am requesting UMB Bank to close my HSA account and, by signing below, I certify that this distribution is (select one):

- made on account of my permanent disability. Funds remaining in my account will be returned to me.
- a transfer to another HSA custodian/trustee. (You must attach a transfer form from your new custodian/trustee.)
- a transfer to my former spouse pursuant to a divorce decree (a copy of the divorce decree is required).
- I no longer have a qualifying high-deductible health plan. Funds remaining in my account will be returned to me as taxable income.

Excess Withdrawal Request

I am requesting an Account Withdrawal in the amount of \$ _____. By signing below, I certify that this distribution is for a return of excess contributions for Tax Year _____ plus earnings on the amount of the excess contribution.

I understand that UMB Bank, n.a. will report this distribution to the IRS in accordance with the type of distribution noted above. In making this Account Closure/Withdrawal Request, I further understand that it is my sole responsibility to determine the tax consequences of such distribution, to properly report the distribution on my Federal income tax return and on Form 8889 for HSA accounts, as well as on any state income tax returns, and to pay any taxes and penalties arising as a result of this distribution (see IRS Publication 969, Health Savings Accounts and other Tax-Favored Health Plans). Applicable account closing fee or check reimbursement fees will apply and will be deducted from the account prior to making the distribution. Please refer to your HSA Deposit Account Terms and Conditions for the amount of the applicable fee.

Account Owner's Name (please print) _____ HSA Account Number _____

Address City _____ State _____ Zip Code _____

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Home Phone Number _____ Work Phone Number _____ Social Security Number _____ Date of Birth _____

Account Owner's Signature _____ Date _____

Please mail completed form to: UMB Bank, n.a.
Mail stop 1170204 – CI Center
PO Box 419226
Kansas City, MO 64141-6226

UMB BANK USE ONLY
Date Closed:
Emp. ID:
Group No.:
Term Date:

Discrimination is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

Español (Spanish): Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 800-842-5357).

中文 (Chinese): 本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471 (TTY: 800-842-5357)。

Tiếng Việt (Vietnamese): Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-722-1471 (TTY: 800-842-5357).

Tagalog (Tagalog): Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-722-1471 (TTY: 800-842-5357).