Health Savings Account (HSA)
Beneficiary Designation Form

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A. Individual HSA Account Owner Information.

FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER	
ADDRESS LINE 1 STREET ADDRESS (NO POST OFFICE BOX)			TELEPHONE NUMBER (DAY) ( )	
ADDRESS LINE 2 PO BOX, APARTMENT OR LOT NO.		CITY	STATE	ZIP CODE

B. Beneficiary Designation. As the named Account Owner of the above-referenced Health Savings Account (HSA), I have the right to designate the beneficiary or beneficiaries to whom any funds remaining in my HSA upon my death are to be paid and, at any time and from time to time prior to my death, to revoke, alter or amend any such designation previously made. Any such designation must be on a form provided by or acceptable to the Custodian and must be filed with the Custodian prior to my death. I hereby revoke completely every such designation previously made by me and I direct that, if I die before distribution of my HSA has been completed, the value of my account shall be distributed to the Primary Beneficiary (ies) named below in the percentage(s) indicated, or in the absence of any percentages, in equal shares. The interest of any Primary Beneficiary who predeceases me shall terminate and the percentage shares of all surviving Primary Beneficiaries shall increase ratably in proportion to the relative sizes of the percentages of such surviving Beneficiaries as originally set forth herein.

PRIMARY BENEFICIARY NAME	ADDRESS	SOC. SEC. NO.	DATE OF BIRTH P	ERCENTAGE

If none of the persons listed above as Primary Beneficiaries are living at my death, I designate the following Secondary Beneficiary(ies) for my HSA, subject to the same distribution rules as are set forth above with respect to Primary Beneficiaries.

SECONDARY BENEFICIARY NAME	ADDRESS	SOC. SEC. NO.	DATE OF BIRTH P	ERCENTAGE

C. Other Provisions. If no Beneficiaries are named on this form or if all the named Beneficiaries predecease me, the HSA funds will be paid to my estate. If my spouse receives the HSA as a result of being named as Beneficiary, my spouse may choose to continue the HSA in his or her name, subject to Custodian's consent, by providing a written election to the Custodian and by signing the forms and providing the information the Custodian requires. For any non-spouse Beneficiary, the HSA terminates as of my date of death and becomes payable. I understand that in certain states, my spouse's consent may be necessary if I wish to name a person other than or in addition to my spouse as Beneficiary, and that I should consult with my attorney before making such a Beneficiary Designation. By making the foregoing Beneficiary Designation, I represent and warrant to the Custodian that this Beneficiary Designation satisfies all legal requirements under applicable law and, on behalf of myself, the Beneficiary(ies), my heirs and my estate, I hereby indemnify and hold the Custodian harmless from and against any and all claims, damages, liabilities, and costs (including attorney's fees) arising as a result of the Custodian's payment of my HSA in accordance with this Beneficiary Designation. Custodian may condition payment to any Beneficiary on satisfactory proof of identity and entitlement to payment.

Signature of Account Owner x	Date:

D. Spousal Consent (If Applicable) Note: The following section should be signed in the event your state requires the consent of your spouse to the designation of a beneficiary other than such spouse with respect to the HSA. This could apply, for example, if you live in a community or marital property state and you designate someone other than or in addition to your spouse as a beneficiary. Consult your attorney or tax advisor for further information.

The undersigned spouse of the Account Owner in whose name the Health Savings Account identified above is opened hereby consents to and joins in the designation of the beneficiary(ies) identified above. To the extent the undersigned spouse is not named as Beneficiary, such spouse relinquishes any interest such spouse may have in the funds contained in the Health Savings Account.

Name of Spouse	Date:
Signature of Spouse x	Date:

Note: Return this form to UMB Bank, n.a., Attention: CI Center, P.O. Box 419226, Mail Stop 1170204, Kansas City, MO 64141

PREMERA | BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association

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).