UMB | Healthcare Services

R12.15

Health Savings Account (HSA) Beneficiary Designation Form

UMB Health Savings Account Number
(17-digit number found on your HSA statement)

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A. Individual HSA Owner Information

First Name	MI	Last Name	Last 4 Characters of SSN
Street Address (No Post Office Box)			Phone (Day)
PO Box, Apartment or Lot #	City	State	ZIP

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.

If you are naming more than four primary beneficiaries and/or more than four secondary beneficiaries, please attach a separate signed and dated sheet, indicating Primary or Secondary, as well as the other required information.

Primary Beneficiary(ies)

Name	Address	Last 4 Characters of SSN	Date of Birth	Percentage

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(ies)

Name	Address	Last 4 Characters of SSN	Date of Birth	Percentage

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**

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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 HSA 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 HSA.

Name of Spouse		Date
Account Owner Spousal Signature	**X**	**Date**

Return completed form:

Via mail to:
UMB Bank
PO Box 540606
Waltham, MA 02454

Via email to:
HSASupport@myumbhsa.com

Via fax to:
1-844-560-6761