



HSA DISTRIBUTION REQUEST FORM

Account Holder Information

HSA Account Number: _____

Name: _____

Distribution Amount: \$ _____

Process my Distribution as a **Direct Deposit** to my personal Checking or Savings Account on file or as a **Check** and mailed to my home address.

For check distributions, a fee of \$1.50 will apply and please allow appropriate time for 1st Class US Mail delivery.

Check here if you want us to enter your medical claim information in the Electronic Claims Vault and process your actual HSA Distribution at a later time.

Please answer the following questions about this distribution from your HSA.

Is this distribution from your HSA for a Qualified Medical Expense? Yes No

If **Yes**, do you wish to provide medical information so that your Plan Service Provider may adjudicate and certify the medical expense? This is an optional service and is not required by HSA regulations.

Yes, I will supply the medical expense to the PSP for review and certification, see below for details

No, I will retain the medical expense information in my personal records and tax receipts

Note: if the medical information is not provided, your PSP cannot provide independent certification for this expense

If **No**, you understand that this distribution will be taxed as income (unless you have offsetting medical expenses) and may also be subject to an excise tax penalty of 10%. It is your responsibility to determine and report the tax consequences of this distribution.

Date of Service MM/DD/YY	Receipt Attached	Patient	Relationship	Provider	Description of Service	Amount
						\$
						\$
						\$
						\$
						\$
TOTAL						\$

ACCOUNT HOLDER'S CERTIFICATION FOR DISBURSEMENT

I certify that this distribution requested from my accounts was incurred by me (and/or my spouse and/or eligible dependents), was not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible Section 213(d) medical expenses and should be treated as a Tax-Free Distribution under my HSA. I will not use the expense reimbursed through this account as deductions or credits when filing my individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ **Date:** _____ / _____ / _____

FOR DISBURSEMENTS, FAX TO (530) 223-7719

OR MAIL TO: VERITAS HEALTH SYSTEMS, P.O. Box 493557, REDDING, CA, 96049-3557