HSA Transfer Form

Instructions

1. Complete the form and send it to current custodian/trustee to initiate a direct transfer of funds from your Health Savings Account (HSA) to your new custodian/trustee.
2. Keep a copy of this form for your records.
3. Fax or mail completed form to:

DASFLEX 5300 S Broadband Lane Sioux Falls, SD 57108
Phone: 605-322-4774 Fax: 605-504-9305 Toll-Free: 1-888-322-2115
Email: dasflex@averahealthplans.com

Account Information

Name on the Account: ______________________ Date of Birth: __________
Social Security Number: ______________________ Phone __________
Street Address: ______________________________
City: ______________________ State: ________ Zip Code __________
Email: ______________________________

Transfer Instructions for Current Custodian/Trustee (current financial institution from which you are *transferring* HSA funds)

Current Custodian/Trustee Name: ______________________________
Custodian/Trustee Phone: ______________________ Contact Name: __________
Street Address: ______________________________
City: ______________________ State: ________ Zip Code __________
Current Custodian/Trustee Account Number: ______________________________

Transfer from (choose one):
☐ Health Savings Account ☐ Medical Savings Account ☐ Individual Retirement Account
Directly transfer (choose one): ☐ All or ☐ partial $__________of my HSA/MSA/IRA
This transfer: ☐ will or ☐ will not close the HSA/MSA/IRA
Please make a check payable as follows: **DASFLEX:** ______________________ HSA
(Account Holder Name)

Mail transfer checks with a copy of this form or other correspondence, including the account holder's name and social security number to: **DASFLEX**
5300 S Broadband Lane
Sioux Falls, SD 57108

Account Holder Signature
I authorize the transfer of the Health Savings Account assets in the manner described above and certify that all information provided by me is true and correct and may be relied upon by the transferring Custodian/Trustee and HealthcareBank. Due to the important tax consequences associated with moving funds into an HSA, I have been advised to seek advice from a tax or legal professional to ensure compliance with related laws. I assume full responsibility for this transaction and will not hold HealthcareBank or Avera Health Plans liable for any adverse consequences that may result.

______________________________ __________
(Signature of HSA Account Holder) Date:

Accepting Health Savings Account Custodian
HealthcareBank agrees to serve as the custodian for the Health Savings Account of the above-named individual, and as custodian, we agree to accept the funds being transferred.

Michael S. Solberg
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Authorized Signature of HealthcareBank