10275 W. Higgins Road, Suite 500
Rosemont, IL 60018
888-FLEXHSA - Phone
847-440-9063 - Fax
flexhsa@flexiblebenefit.com - Email
www.flexhsa.com

HSA ROLLOVER AUTHORIZATION

(*For FSAs and HRAs*)

A ACCOUNT INFORMATION

Account Holder's Name: _____

Account Holder's Social Security No.: _____ Account Holder's Phone No.: _____

Present Employer: _____

Present Employer Address: _____

City: _____ State: _____ Zip: _____

Employer Account No.: _____ Employer Phone No.: _____

B ROLLOVER TO HSA

To request a rollover to an HSA, please review the details for each type of rollover, check the appropriate box and provide the dollar amount of the rollover. These rollovers do not count toward your maximum annual contribution limit.

- ☐ **Flexible Spending Account "FSA" Rollover to HSA (Direct)** - This is a one-time tax free rollover from the employer of a Health FSA account (a "qualified HSA distribution") to an HSA, provided your FSA account was in effect on September 21, 2006 and the rollover is limited to the lesser of the amount in the FSA on that date or the amount in your FSA account as of the rollover.

  Amount from FSA: $ _____

- ☐ **Health Reimbursement Arrangement "HRA" Rollover to HSA (Direct)** - This is a one-time tax free rollover from the employer of a Health HRA account (a "qualified HSA distribution") to an HSA, provided your HRA account was in effect on September 21, 2006 and the rollover is limited to the lesser of the amount in the HRA on that date or the amount in your HRA account as of the rollover.

  Amount from HRA: $ _____

C ACKNOWLEDGEMENT AND SIGNATURE

We acknowledge that the assets listed above are held in an FSA/HRA. We understand that FlexHSA reserves the right to review all assets being rolled over prior to final acceptance as successor custodian. To expedite the rollover, we have provided FlexHSA with complete information.

Account Holder's Signature: _____ Date: _____

Employer Signature: _____ Date: _____

This form will be sent to your Present Employer by regular Mail unless overnight delivery is requested:

- ☐ Yes, I authorize FlexHSA to send by overnight delivery (*A $25 fee will be charged to the account holder's account*).

Please return all forms to:
Flexible Benefit Service Corporation
10275 W Higgins Suite 500
Rosemont IL 60018
Attn: FlexHSA