DISTRIBUTION REQUEST FORM
Health Savings Account (HSA)

Complete this form to request a distribution from your TASC HSA for one of the reasons indicated below. All fields required.
For death distributions, complete the *Death Distribution Request Form*.

Submit this completed form to TASC via one of the following methods:	Fax	Mail
	(608) 661-9601	TASC, PO Box 7308 Madison, Wisconsin 53704-7308

For questions, please call TASC at **800-422-4661** with your TASC ID # available.

ACCOUNTHOLDER INFORMATION

TASC ID #:		Social Security Number:			
First Name:		MI:		Last Name:	

PROCESSING INFORMATION

I direct TASC to make a distribution from my HSA in the form of the following type (select only one type per form):

☐ **Normal**	For payment of qualified medical expenses; save your receipts.	
☐ **Disability**	If the disability renders you unable to engage in any substantial gainful activity and it is medically determined that the conditional will last continuously for at least 12 months or lead to your death. Disability distributions are subject to ordinary income tax.	
☐ **Prohibited Transaction**	Use of HSA funds for anything other than a qualified medical expense; if not corrected in a timely manner, IRS penalties may be imposed.	
	Amount of Distribution $	
☐ **Excess Contribution Removal**	**Amount of Excess Contribution $**	
	Date excess contribution occurred:	
☐ **Rollover**	☐ Partial Rollover: $_____ **or** ☐ Liquidate my entire account balance	
	This Rollover ☐ **will** / ☐ **will not** close my existing HSA*	
	Check will be made payable to HSA Accountholder and mailed to your address on file. IMPORTANT NOTE: The IRS Code limits the number of rollovers that may be taken, how quickly rollovers must be completed and how the trustee or custodian must report the transaction. If you need additional information, please contact your tax advisor. By selecting this option, you are certifying to the bank that you have satisfied the rules and conditions applicable to your rollover and that you are making an irrevocable election to treat the transaction as a rollover. The funds you receive from the distribution of an HSA must be deposited into another HSA within 60 days from when you receive them. You are entitled to one distribution per year per HSA which may be rolled over. You are entitled to roll over the same assets only once in a twelve (12) month period.	
☐ **Transfer to New Custodian**	☐ Partial Transfer: $_____ **or** ☐ Liquidate my entire account balance	
	This Transfer ☐ **will** / ☐ **will not** close my existing HSA*	
	Check will be made payable to the receiving Administrator/Trustee/Custodian for the benefit of the HSA Accountholder and mailed to the address you provide below. It is the HSA Accountholder's responsibility to forward the check to the new Administrator/Trustee /Custodian.	
	Name of Receiving Administrator/Trustee/Custodian:	
	Street Address:	
	City:	**State:** **ZIP:**

****AUTHORIZATION SIGNATURE REQUIRED ON PAGE 2****

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AUTHORIZATION

I certify that I am the HSA Accountholder, or an individual authorized to execute this transaction. I have read and understand the instructions and any rules or conditions relating to this transaction. I assume full responsibility for this transaction and will not hold TASC or State Bank of Cross Plains (SBCP) liable for any adverse consequences that may result. I have not received tax or legal advice from TASC or State Bank of Cross Plains and, if necessary, will seek the advice of a tax or legal professional to ensure my compliance with related laws. All information provided by me is true and correct and may be relied upon TASC and State Bank of Cross Plains.

*If account closure is requested via Rollover or Transfer, I authorize the TASC to liquidate the investments in my HSA Investment Account and wait 10 days to allow any outstanding debit card transaction (if debit card is applicable to my account) to settle before mailing the check for any remaining account balance, less any applicable account closing fee.

_____ _____

HSA Accountholder Signature **Date**