# Account authorization form

HealthEquity®

Mail or fax completed forms to:

**Address:** **HealthEquity, Attn: Member Services**
PO Box 14374 Lexington, KY 40512

**Fax:** 801.727.1005

## Authorization for account information

To authorize HealthEquity to provide account information to another party, complete this form.

## Primary account holder information

| Last name | First name | | M.I. |
|---|---|---|---|
| Street address | City | State | ZIP |
| Email address (required) | Daytime phone ( ) | SSN or HealthEquity ID number | |

## Authorization for account information

I authorize a HealthEquity member services representatives to provide the following information about my HealthEquity health savings account (HSA), medical savings account (MSA) or reimburse arrangement (RA) to the authorized individual listed on this form as indicated below. Check all that apply.

- ☐ Account information, including account balance, recent transactions, and payment details.
- ☐ Information to perform account maintenance and request payments/distributions to be made from the account to any provider or bank account.
- ☐ Information to receive the same billing information available to the account holder necessary to make a payment.
- ☐ Information to request a personal payment method for distributions from the account holder's HSA or MSA for qualified expenses as a dependent (personal payment method).
- ☐ Account Information, including protected health information necessary for your employer to assist with claims issues or benefits problems.

I understand and agree that the individual named below is authorized to execute the above.

_____ _____

Signature of account holder Date

If at any time you need to alter this authorization form, please contact HealthEquity at 866.346.5800.

| Name of authorized individual | Authorized individual's date of birth |
|---|---|
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