American Fidelity Health Services Administration
A member of the American Fidelity Group

Toll free: 1-866-326-3600
Phone: (405) 523-5699
Fax: (405) 523-5072
Website: www.afhsa.com
Email: hsa-support@af-group.com

HEALTH SAVINGS ACCOUNT
Distribution Request Form

You can complete this form and fax it to (405) 523-5072 or mail it to: American Fidelity Health Services Administration, 2000 N Classen Blvd. 7E Oklahoma City, OK 73106. A manual distribution fee of $10.00 will be automatically deducted from your health savings account for each distribution form submitted. To avoid this distribution fee, simply login to your online account at www.afhsa.com and request an on-line withdrawal.

A. General Information

Name		Social Security #	
Employer Name (if applicable)		Address	
Email address		City, State, Zip	
Daytime Phone		Home Phone	

B. Distribution Information

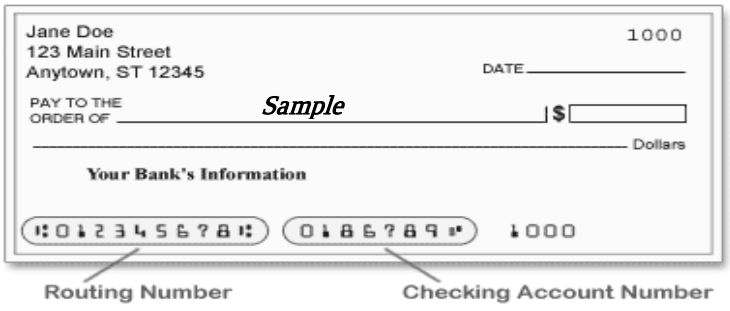
Distributions can be made directly from your HSA 24/7 by logging into your account.

Distribution amount	$	☐ Check ☐ Direct Deposit	Method of distribution (For direct deposit, complete Section C)
Do not send your eligible medical expense receipts with your distribution request. All receipts should be kept for your tax records.			
Reason for distribution	☐ Eligible Medical Expense ($10 fee) ☐ Excess Contribution Removal ($15 fee) ☐ Ineligible Medical Expense ($10 fee)	☐ Yes ☐ No	Will this distribution close the account? ($25 closing fee)

C. Direct Deposit Information (if applicable)

Bank Name		Bank Phone	
Deposit Account	☐ Checking ☐ Savings	Bank Routing Number	
		Bank Account Number	

ATTACH COPY OF VOIDED CHECK/SAVINGS WITHDRAWAL FORM HERE



☐ I certify that I am the proper party to receive payment(s) from the HSA and that all information provided by me is true and accurate. I further certify that no tax advice has been given to me by American Fidelity Health Services Administration (AFHSA). All decisions regarding this distribution are my own. I expressly assume the responsibility for any adverse consequences which may arise from this distribution and I agree that AFHSA shall in no way be held responsible.

☐ I hereby authorize (AFHSA) to make deposits to my account. I understand that it will take approximately 7-10 business days from the date that AFHSA receives this authorization for the direct deposit to occur. I understand that it is my responsibility to notify AFHSA of any changes to my bank account number and routing number. If I fail to notify AFHSA of any changes, I will be responsible for reimbursing AFHSA for all applicable bank charges.

Signature of Accountholder _____ Date _____

FOR OFFICE USE ONLY	RECEIVED BY:	PROCESSED ON:	PROCESSED BY: