Health Savings Account (HSA) Change Form

Please use this Form to make changes to your HSA information.

Fax to the number below or mail to:
Trust Administrators, Inc., P.O. Box 20710, Oakland, CA 94620 • www.trustadmin.com

1. Employer

2. Employee Social Security Number

❑ Check box if new address
Home Street Address

City State Zip code

Daytime ( ) Email Address

3. Please check "any" of the following:

❑ Name Change of Account Holder. Your New Name:

❑ Change in Health Care Provider. New Provider's Name: Per Pay Period/ Month/Other:

❑ Change in Deductible. New Deductible Amount: $ Per Pay Period/ Month/Other:

❑ Change in Contribution. New Contribution Amount $ Per Pay Period/ Month/Other:

❑ Change Coverage ❑ Add Individuals ❑ Delete Indicate the change and list individuals below at number "4"
❑ Individual ❑ Child(ren) ❑ Spouse ❑ Family (Spouse and Child(ren)

4. Identify the Individuals You Changed

Name	Date of Birth	Relationship	Social Security #

5. Account Holder Authorization

▶

Signature of Account Holder **Date**

Routing: Original for Employer • Copies for TAI & Account Holder
800-932-3539 • Fax: 510-451-8611