



# HSA Withdrawal/Disbursement

Please complete this form to withdraw funds from your WealthCare Saver\* Health Savings Account (HSA). You may wish to review IRS Publication 969 found at [www.irs.gov/pub/irs-pdf/p969.pdf](http://www.irs.gov/pub/irs-pdf/p969.pdf).



##37PNC#####



**Fax completed form to:**  
855.588.1028



**Mail completed form to:**  
WealthCare Saver  
P.O. Box 162177  
Altamonte Springs, FL 32716



**Questions about this form?**  
855-399-3035  
6:00 AM - 6:00 PM MST

## Section 1: Account Information

ACCOUNT NUMBER (12 digits beginning with 601)

LAST NAME

FIRST NAME

MIDDLE INITIAL

EMPLOYER NAME

SOCIAL SECURITY NUMBER

EMAIL ADDRESS

TELEPHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP CODE

## Section 2: Withdrawal/Disbursement Instructions (TC161)

Please indicate the amount you would like to withdraw from your HSA and whether you would like the funds distributed to you as a check or via ACH transfer. Funds must be available in your deposit cash balance. If funds are not in your deposit cash balance, but available in your investment account portfolio balance, you must initiate a liquidation request prior to your disbursement being processed.

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WITHDRAWAL AMOUNT

☐ Check

☐ Deposit funds electronically to the direct deposit account on file.

**Please note: If no bank account on file, a check will be mailed to the address on the account.**

## Section 3: Signature

I certify that I am the HSA account holder and legally authorized to receive payment(s) from this HSA and that all information provided by me is true and correct. I further certify that no tax advice has been given to me by WealthCare Saver as Custodian, or its affiliates. I understand that I may consult a tax professional or legal counsel. All decisions regarding this distribution are my own. I assume full responsibility for this distribution and will not hold WealthCare Saver as Custodian, or its affiliates, liable for any adverse consequences that may result.

I acknowledge that I have read and understand the terms and conditions applicable to a distribution as set forth in the Custodial Agreement provided when opening this HSA. I understand that any applicable fees will be deducted from the distribution amount requested (Refer to the HSA Fee Schedule on the Portal).

LEGAL SIGNATURE OF ACCOUNT HOLDER (FIRST & LAST NAME REQUIRED)

DATE