Health Savings Account Information Authorization Form

Use this form to authorize another individual access to information regarding your HSA. Submit completed form to: Benefit Extras, Inc. (TPA) via fax to **952.435.8435 (toll-free fax 800.886.8793),** secure email to **flex@benefitextras.com** or mail to **Benefit Extras, Inc., P.O. Box 1815, Burnsville, MN 55337.**

If you have any questions regarding this form, please call **952.435.6858 or toll-free at 866.435.6858 or contact us via our website at www.benefitextras.com.**

f

*Required Fields

Part I Profile Information

*Consumer Name (First, MI, Last)	*Employer Name (If sponsored by an employer plan)	
*Birth Date (MM/DD/YYYY)	*Social Security Number	*Day Telephone
*Address		
*City	*State	*Zip
Email Address		

Part II Authorized Individual Information – I authorize HSA Administrator's customer service representatives to provide information regarding my HSA, including but not limited to the balance and transaction history, to the individual named below.

I understand and agree that:

- the individual named below will **not** be authorized to perform my account maintenance; and
- this authorization pertains to information obtained from customer service only; and
- I am the sole individual authorized to access and maintain my account online.

*Authorized Individual Name (First, MI, Last)		
*Address		
*State	*State	*Zip
*Phone Number		

Part IV Consumer Signature

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 Benefit Extras, Inc. or WEX Inc. liable for any adverse consequences that may result. I have not received tax or legal advice from Benefit Extras, Inc. or WEX Inc., 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 by Benefit Extras, Inc. I acknowledge that changes specified on this form shall become effective as soon as administratively feasible upon the receipt of this form. I acknowledge that this form may be electronically signed, and I agree that the electronic signature(s) appearing on this document are the same as handwritten signatures for the purpose of validity, enforceability, and admissibility.

*Consumer Signature	*Date