Health Savings Account
Power of Attorney Disability / Incapacity Form

Instructions:

1. Complete all sections of this form.
2. **Signatures must be notarized.**
3. 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.**
4. 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.**

*Required Fields

Part I Consumer Information

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

Part II Power of Attorney Designation

* Attorney-in-fact Name (First, MI, Last)		
*Birth Date (MM/DD/YYYY)	*Social Security Number	*Day Telephone
*Address		
*City	*State	*Zip

Benefit Extras, Inc. and WEX Inc. is hereby authorized to recognize the signature subscribed below in the payment of funds or transactions of any business for this account. All transactions shall be governed by applicable laws and the Health Savings Account Custodian Agreement. To the extent allowed by law, this authorization shall survive my disability or incapacity, and shall remain in effect until Benefit Extras, Inc. receives written notice of revocation and a reasonable opportunity to act on such notice.

Signature

By signing below, I authorize the attorney-in-fact identified above to perform any act I may perform pursuant to my HSA Custodial Agreement with Benefit Extras, Inc. This Power of Attorney is effective upon my disability or incapacity. I shall be considered disabled or incapacitated for purposes of this Power of Attorney if a physician certifies in writing that, based on the physician's medical examination of me, I am mentally incapable of managing my financial affairs. I authorize the physician who examines me for this purpose to disclose my physical or mental condition to another person for purposes of this Power of Attorney. This authorization includes, for example, the ability to: (1) endorse, cash, or deposit checks or other items payable to my order, (2) withdraw funds from this account via any means allowed for this account, including but not limited to checks, ACH and wire transfers; and (3) give instructions for the handling of any and all matters in connection with this account. I understand the powers I give to my attorney-in-fact, and any limitations on those powers are between the attorney-in-fact and me, even if Benefit Extras, Inc. and WEX Inc. have express written notice of those powers. I agree to hold Benefit Extras, Inc. and WEX Inc., harmless and be responsible for any damages or costs incurred due to my HSA Administrator's reliance on this Power of Attorney.

*Signature of HSA Account Holder	*Date
*Signature of Attorney-in-fact	*Date

BENEFIT EXTRAS, INC.

Health Savings Account
Power of Attorney Disability / Incapacity Form

*Notary to complete

Subscribed and sworn to before me this _____ day of _____, 20____

Notary Public Signature: _____

Revocation of Power of Attorney

I hereby revoke the appointment named Power of Attorney and have notified them of this change. I understand that Benefit Extras, Inc. and WEX Inc. may charge the account for the amount of any check or pre-authorized transactions dated on or before this date if they have been authorized by my attorney-in-fact.

*Signature of HSA Account Holder	*Date
*Signature of Attorney-in-fact	*Date

*Notary to complete

Subscribed and sworn to before me this _____ day of _____, 20____

Notary Public Signature: _____