BENEFIT EXTRAS, INC.

Health Savings Account Name Change Form

Use this form to update your HSA to reflect a change in your name. 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.**

*Required Fields

Part I Original 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 New Profile Information – Include documentation of your name change such as a certified copy of marriage license, adoption forms, formal name change documentation, etc. when submitting this form.

*Consumer Name (First, MI, Last)		
*Address		
*State	*State	*Zip
Email Address		

Part III Debit Card Reorder Request

Would you like to receive a new debit card to reflect your name change? ☐ Yes ☐ No

*A $10.00 fee for two additional cards will be applied to your account for your debit card reorder.

Part IV Consumer Signature

I agree to be bound by the terms and conditions of the Custodial Agreement and Cardholder Agreement with 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