



**HEALTH SAVINGS ACCOUNT
TRANSFER REQUEST**

An Independent Licensee of the Blue Cross Blue Shield Association

Account Holder Information (please print)			Spending Account ID #							
Last Name _____ First Name _____ Middle Initial _____			S	A						
Street Address _____			Social Security # (if SA# is not known)							
City _____ State _____ Zip _____			Daytime Phone							
Email address _____										

Transfer Instructions

This transfer will be into an HSA.

Directly transfer: all or part of the account identified below to **Further** as Custodian of the _____ account.
(Account Holder's Name)

This transfer: will will not close the account.

A. Payment Amount (select one): My entire balance The following amount. \$ _____

B. Payment Schedule and Investments (select one):
 Immediately liquidate all investments and send cash proceeds. Liquidate the investments as identified below:

Account number or investment	Dollar amount requested
	\$
	\$
	\$

Current HSA Administrator (transferring FROM)

Trustee/Custodian's Name _____		Trustee/Custodian's Account ID# _____	
Street Address _____			
City _____		State _____	Zip _____
Trustee/Custodian's Phone# _____		Trustee/Custodian's Fax # _____	

Signature of HSA Account Owner

I authorize the transfer of the account assets in the manner described above and certify that all of the information provided by me is correct and may be relied upon by Further.

HSA Account Owner Signature Date

Account Holder Instructions: Please send this completed form back to your previous administrator for processing.

Administrative Check Mailing Instructions: Please mail the check to address listed below.

PO Box 860684 Minneapolis, MN 55486-0684	Overnight: Lockbox 860684 1200 Energy Park Dr St Paul, MN 55108-0684
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