



14510 'F' St. Omaha, NE 68137

Transfer Instructions

Complete my transfer as directed. Note: Penalties and market fluctuation may affect the distribution amount.

Name: _____ Date: _____
Please Print or Type Name

Type of Transfer

Please Select One:

- HSA to HSA Archer Medical Savings (MSA) to an HSA

Transferor Custodian / Trustee Request

My HAS/Archer MSA custodian/trustee (transferor), _____, should transfer the assets identified in the Transfer Instructions section.

Transferor Address:	Transferor Phone Number	Transferor HSA/Archer MSA Account Number

Payment Amount (select one):

- My entire HSA/ Archer MSA balance.
- A portion of my HSA/Archer MSA balance. \$ _____

Payment Schedule and Investment (select one):

- Immediately liquidate all investments and send cash proceeds.
- Send all investment in kind.
- Liquidate the investments as identified below:

Account Number or Investment	Dollar Amount or # of shares	Transaction Date	Send:
			<input type="checkbox"/> Cash Proceeds <input type="checkbox"/> In Kind
			<input type="checkbox"/> Cash Proceeds <input type="checkbox"/> In Kind
			<input type="checkbox"/> Cash Proceeds <input type="checkbox"/> In Kind
			<input type="checkbox"/> Cash Proceeds <input type="checkbox"/> In Kind
			<input type="checkbox"/> Cash Proceeds <input type="checkbox"/> In Kind
<input type="checkbox"/> Other _____ _____			

Delivery Instructions

- Transferor HSA Account Number _____
- Make check payable to or certificate registration in the name of _____
 as **custodian** / **trustee** for the HSA of _____

I (We) certify that we are establishing this health savings account (HSA) exclusively for the purpose of paying or reimbursing qualified medical expenses of the primary account owner, spouse, and dependents. I (We) are eligible to contribute to this (HSA), specifically, that I (we) am covered under a high deductible health plan (HDHP); and not also covered by any other health plan that is not an HDHP, except as allowed by the Internal Revenue Service; is not enrolled in Medicare; and cannot be claimed as a dependent on another person's tax return.

I (We) certify the above information to be true in every respect. I (we) authorize the credit union to make whatever credit inquiries it deems necessary in conjunction with my (our) credit application, account opening or in the course of review or collection of any credit extended in reliance on the application including, without limitation, inquiries to any agency of government – federal, state or local. I (we) authorize and instruct any person, governmental agency or consumer reporting agency to compile and furnish the credit union any information it may have or obtain in response to such credit inquiries and agree that same shall remain the property of the credit union whether or not credit is extended or account is opened.

SIGNATURE _____ DATE _____

SIGNATURE _____ DATE _____