



MEDICAL MUTUAL®

HSA Information Change Form

Instructions: Use this form to change an existing/already established Health Savings Account (HSA). Complete this form and mail it to: Avidia Bank, P.O. Box 370, Hudson, MA 01749. For assistance, call 1-800-525-9252 or send an email to: myspendingaccounts@MedMutual.com.

Accountholder Initial Personal Information:

First Name	MI	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Account #	Social Security #	Birth Date (mm/dd/yyyy)
<input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

Amendment Type: This is an amendment to an existing HSA due to: *(Check all that apply.)*

- ☐ Adding an authorized signer (see section C)
- ☐ Changing the authorized signer's name due to marriage or legal decree (see section C)
- ☐ Revoking/removing authorized signer (see section D)
- ☐ Designation of beneficiary (see section E)

Section B: Account Options

Complete this section if you want new checks or debit cards ordered at this time. Complete the *Authorized Signer* section on page 2 for spousal or third party access to your account.

Please replace my HSA debit card issued for my account with my name change

Please order a HSA debit card

Section C: Authorized Signer (additional or secondary signer)

If you wish to designate an authorized signer on your account, please complete all of the required fields below. If you are unable to provide all of the required information on your authorized signer, they will not be added to your account. You hereby designate the following individual as an authorized signer on your HSA. By designating an authorized signer on your account, you authorize the person designated below as "authorized signer" to transact business with and give instructions to Avidia Bank regarding your HSA; make deposits or withdrawals by any means acceptable to Avidia Bank, including paper and electronic methods such as ACH and Internet-generated transactions; receive and have access to account information, including balances and transactions; endorse any instruments such as checks, orders or other documents for the payment of funds; and to otherwise serve as agent for your Avidia Bank HSA.

You specifically authorize Avidia Bank, as custodian of your HSA, to rely upon this authorization and designation until such time, if any, that Avidia Bank receives a written revocation of this authorization, and has had a reasonable time to act upon the revocation. You understand that you are responsible for ensuring that your authorized signer reads and understands Avidia Bank account documents which have been provided to you. You hold harmless and indemnify Avidia Bank against any claims against or losses Avidia Bank may suffer arising out of Avidia Bank's reliance on this authorization, and release Avidia Bank from any liability arising from such reliance, unless otherwise prohibited by law. You understand that you bear sole responsibility for any tax consequences that result from any actions taken by the authorized signer regarding your account.

NO PRESENT OR FUTURE OWNERSHIP OR RIGHT OF SURVIVORSHIP IS GIVEN TO THE AUTHORIZED SIGNER BY THIS AUTHORIZATION. UPON NOTICE TO AVIDIA BANK OF YOUR DEATH, THIS AUTHORIZATION TERMINATES, AND RIGHTS TO FUNDS IN YOUR ACCOUNT WILL BE TRANSFERRED TO YOUR BENEFICIARIES. IF YOU DID NOT NAME A BENEFICIARY, YOUR ACCOUNT BALANCE WILL ONLY BE PAYABLE TO YOUR ESTATE.

Authorized Signer Personal Information:

ALL FIELDS REQUIRED (P.O. Box Not Accepted)

Previous First Name	MI	Previous Last Name	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Current	MI	Current Last Name	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Social Security #	Date of Birth		
<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>		
Driver's License #	License State	Issue Date	Expiration Date
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Street Address			
<input type="text"/>			
City	State		Zip
<input type="text"/>	<input type="text"/>		<input type="text"/>
Home Phone	<input type="text"/> - <input type="text"/> - <input type="text"/>		

Section D: Revoke Authorized Signer

Authorized signer to be removed from account:

Authorized Signer First Name	MI	Authorized Signer Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>

Please complete one of the sections below.

☐ **Revoked By Accountholder** *NOTE: If a debit card has been issued to the authorized signer, it will be deactivated.*

The authorized signer authority previously granted to the authorized signer listed above is hereby terminated. I understand that I am responsible for recovering any debit cards which are in the possession of the authorized signer.

☐ **Revoked By Authorized Signer**

As authorized signer I understand that I am responsible for returning any debit cards which are in my possession to the account holder.

Section E: Designation of Beneficiary – This information replaces all previous beneficiary information

The following individual(s) or entity shall be my primary and/or contingent beneficiary(ies). If neither primary nor contingent is indicated, the individual or entity will be deemed to be the primary beneficiary. If more than one primary beneficiary is designated and no distribution percentages are indicated the beneficiaries will be deemed to own equal share percentages in the account. Multiple contingent beneficiaries with no share percentage indicated will also be deemed to share equally. If a primary or contingent beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining beneficiary(ies) shall be increased on a pro-rated basis. If no primary beneficiary(ies) survives me, the contingent beneficiary(ies) shall acquire the designated share of my account. I understand that I may change or add beneficiaries at any time by completing and delivering the proper form to Avidia Bank. Avidia Bank has provided no tax or legal advice to me regarding my beneficiary designation.

Name & Address of Individual (or Trust and Trustee)	Date of Birth (Creation date, if Trust)	Social Security # (TIN, if Trust)	Relationship	Primary or Contingent	Share %

Spousal Consent

This section should be reviewed if either the trust or the residence of the accountholder is located in a community or marital property state and the accountholder is married. Due to important tax consequences of giving up one's community property interest, individuals signing this section should consult with an independent legal or tax advisor.

☐ I am not married – I understand that if I become married in the future, I must complete a new Designation of Beneficiary form.

☐ I am married – I understand that if I chose to designate a primary beneficiary other than my spouse, I am responsible for obtaining her consent if required by law

Signatures

I certify that the information provided above and attached hereto is accurate and request that any information provided previously be updated with the information here.

Accountholder Signature

Date

To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. What this means to you: When you open an account we will need you and your authorized signer to provide name, street address, date of birth and other information that will allow us to identify you and your authorized signer. We may also ask to see your driver's license or other identifying documents.