American Chartered Bank

HEALTH SAVINGS ACCOUNT
HSA /MSA Rollover Request Form

HSA ACCOUNT HOLDER INFORMATION:

American Chartered Bank
HSA Account Number: ____________________

☐ Check this box if rollover will fund a new HSA account and include your HSA account application with this rollover form.

Name: ____________________
(First) (Initial) (Last)

Address : ____________________

City: ____________ State: ____________ Zip Code: ____________

Home Phone #: ____________ Business Phone #: ____________

e-Mail Address (optional): ____________________

ROLLOVER ELIGIBILITY REQUIREMENTS:

A rollover is a process to move money from a Medical Savings Account (MSA) or Health Savings Account (HSA) to a Health Savings Account at American Chartered Bank. The Internal Revenue Code limits how many rollovers may be initiated, how quickly rollovers must be completed, and how the Trustee or Custodian must report the transaction. By properly completing this form, you are certifying to the Trustee or Custodian that you have satisfied the rules and conditions applicable to your rollover, and that you are making an irrevocable election to treat the transaction as a rollover.

Rollover requirements are described below:

Timelines: The funds you receive from the distributing MSA or HSA must be deposited into a HSA within sixty (60) calendar days after you receive them. Weekends and holidays are included in this count. There are generally no exceptions to the 60-day rule, and the IRS cannot grant extensions. Receipt generally means the day you actually have the funds in hand. For example, the 60 days would begin on the day following the day you pick up a check from the Trustee or Custodian, or you receive a check in the mail.

Twelve-Month Restriction: You are entitled to roll over the same assets only once in a twelve (12) month period. Twelve (12) months must elapse between the time you receive a distribution of the assets to be rolled over and the time you receive another distribution of those same assets for rollover purposes.

In summary, for a rollover to qualify as eligible, the answer to each of the following questions must be no.

(a) Have more than sixty (60) days elapsed since you received the distribution from the MSA or HSA from which you are requesting a distribution? ☐ Yes ☐ No

(b) Did you receive any other distributions from the distributing MSA/HSA during the preceding 12 months, which you also rolled over? ☐ Yes ☐ No

(c) Have the assets involved in this transaction been previously rolled over from a MSA or HSA within the past twelve (12) months? ☐ Yes ☐ No

ROLLOVER AMOUNT:

Rollover Amount: $ ____________________

ACCOUNT HOLDER SIGNATURE:

I have read and understand the rollover rules and conditions on this form, and I meet the requirements for making a rollover. Due to the important tax consequences of rolling over funds or property to a HSA, I have been advised to see a tax professional. All information provided by me is true and accurate, and may be relied upon by the Custodian. I assume full responsibility for this rollover transaction, and will not hold the Custodian liable for any adverse consequences that may result. I hereby irrevocably designate this contribution as a rollover contribution.

____________________ Signature - Health Savings Account Holder Date

____________________ Signature of Witness (Required for Rollover) Date

____________________ Printed Name of Witness

Please mail this form and check to:

American Chartered Bank
HSA Processing
PO Box 5994
Carol Stream, IL 60197-5994

Phone (847) 407-2603 Fax (847) 407-2633

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