



Southwest Securities, Inc. and/or Broker/Dealers for which it clears
 Southwest Securities, Inc. Member NYSE/FINRA/SIPC

New Account
 Update

HSA Distribution Request

1. General Information.

SWST Account Number: _____ Date: _____

Organization: _____

Full Name (First, Middle, Last)	SSN/Taxpayer ID #	Date of Birth
Address	City	State/Province Country Zip

2. Distribution Reason.

- 1. Distribution used to pay or reimburse for qualified medical expense
- 2. Distribution not used to pay or reimburse for qualified medical expenses and no other exception applies
- 3. Distribution after becoming eligible for Medicare (age 65)
- 4. Permanent Disability (if you are disabled within the meaning of section 72(m)(7) of the Internal Revenue Code)
- 5. Death (Attach copy of the death certificate)
- 6. Removal of Excess Contribution plus earnings for year _____. Is the contribution plus earnings being removed in the same year? Yes or No
 (Attach the earnings worksheet.)
- 7. Divorce (Attach copy of divorce decree)

3. Distribution Type. (Check ONE)

- A. Distribute my entire account and close my account.** (Note: There is a \$25 closing fee.)
- B. Distribute cash from my account:**
 Gross Amount: \$ _____
- C. Distribute the following securities.** (Please provide # of shares. We cannot process the request on \$ amount.)

Asset Description	Quantity	Asset Description	Quantity

4. Distribution Method. (Check ONE)

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> 1. Check <input type="checkbox"/> 2. Transfer to SWST account # : _____ <input type="checkbox"/> 3. Stock Certificate <input type="checkbox"/> 4. ACH (Must also complete the ACH Form on back) | <ul style="list-style-type: none"> <input type="checkbox"/> 5. Wire (Fill in the following & note that there is a \$15 wiring fee.)
 Bank name: _____
 City: _____ State: _____ Country: _____
 Routing #: _____ Account #: _____ |
|---|--|

5. Signatures.

I certify that I am the proper party to receive payment(s) from this HSA, and that all information provided by me is true and accurate. I understand that although HSAs are not subject to withholding, I am still liable for the payment of Federal income tax on the taxable amount of any distribution. I understand that any amounts withdrawn that are not used to pay or reimburse for qualified medical expenses may be subject to income taxes and penalties. I also understand that I may be subject to tax penalties under the estimated tax payment rules if my payments of estimated tax are not adequate. I certify that no tax advice has been given to me by the Custodian or Trustee, that distributions are reported to the IRS, and that all decisions regarding this withdrawal are my own. The Account Beneficiary is solely responsible for determining the taxability or non-taxability of any distribution from this HSA. I expressly assume the responsibility for any adverse consequences which may arise from this withdrawal and I agree that the Custodian or Trustee shall in no way be responsible for those consequences.

Participant's or Beneficiary's Signature: _____ Date _____

Participants or Beneficiary's printed name _____