Distribution Request for Health Savings Accounts (HSAs)

For GroupCare or Congregational Employee Plan

Mail this request to MMA, Attn: FlexChoice/HSA or fax to (574) 537-6642.
Please do **not** send copies of bills with this.

Employer ______________________________

Account holder's name ______________________________

Social Security number ______________

Amount requested $______________

Distribution requests will all be withdrawn first from funds you have in the money market. If the amount you have requested is more than you have in your money market account, please tell us from which investment fund to withdraw the money. If you do not tell us where to take the money from, we will withdraw from the funds in the order they're listed below.

☐ Intermediate Income. Amount $______________

☐ Value Index. Amount $______________

☐ Core Stock. Amount $______________

☐ International Stock. Amount $______________

Account holder's signature ______________________________ Date ______________

Description for your records (Complete only if you want the doctor's name or date of visit on the check stub):

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Office use only

Date received ______________

Date processed ______________

By ______________

Check number ______________

Date mailed ______________

MMA®

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