Principal Trust Company

A member of

Mailing Address:
P.O. Box 8963
Wilmington, DE 19899-8963
800-209-9010 Fax: 302-999-9554

Health Saving Account – Distribution Request Form

1. Account Holder Information (Please Print)

Name:			
Address:	City:	State:	ZIP Code:

Brokerage Firm and Account Number:	Social Security Number:	Daytime Phone Number:

2. Type and Method of Distribution (Please select from both the Type and Method Listings)

This will be a: ☐ Total Distribution ☐ Partial Distribution

Distribution Type	Distribution Method
☐ Normal	☐ In-Cash (liquidating assets)
☐ Excess Contribution*	☐ In-Kind (reregistering assets/certificate form)
☐ Disability	☐ Direct Transfer
☐ Death	

* Is the excess contribution being removed before your tax-filing deadline, including extensions?

☐ Yes ☐ No

Total interest being removed $ ____________________ .

3. Amount of Distribution (for Partial Withdrawals only)

I would like to withdraw from my account: $ ____________________ or ____________________ %

Liquidate/ Reregister (please check one)	Shares, Units, or Amount	Name of Asset	Account Number	Broker Held	Fund/ Agent Held
☐ L ☐ R				☐	☐
☐ L ☐ R				☐	☐
☐ L ☐ R				☐	☐

4. Payment Information

Note: All distributions will be issued to the Account Holder and mailed to the address in Section 1 unless otherwise directed in this section.

Make Check Payable and Issue to: Financial Institution or Personal Account Information

Name of Financial Institution:			
Mailing Address:	City:	State:	ZIP Code:

Account Number:	Name of Contact at Financial Institution:	Telephone Number:

5. Signatures

Account Holder Signature:	Date: