

[Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email Address]

[Date]

[HSA Administrator Name]
[HSA Provider Address]
[City, State, Zip Code]

Subject: Request to Close Health Savings Account - Account Number: [Your Account Number]

To Whom It May Concern,

Please accept this letter as formal authorization to close my Health Savings Account (HSA) effective immediately. This request is being made because my employer has changed healthcare providers, and I will be utilizing a new HSA administrator moving forward.

Regarding the remaining balance in my account, please perform the following action (select one):

☐ **Option 1: Direct Rollover.** Please transfer the total remaining balance via a trustee-to-trustee transfer to my new HSA provider.

New Provider Name: [New Bank Name]

New Account Number: [New Account Number]

Transfer Mailing Address: [New Provider Mailing Address]

☐ **Option 2: Distribution by Check.** Please issue a check for the total remaining balance, minus any applicable closing fees, and mail it to my home address listed above. I understand that I am responsible for depositing these funds into my new HSA within 60 days to avoid tax penalties.

Please waive any applicable "Account Closure" or "Transfer" fees if possible due to this employer-mandated change. If fees are mandatory, please deduct them from the final balance before distribution.

Please provide a final account statement for my tax records once the closure is complete.

If you require any further information, please contact me at [Your Phone Number].

Sincerely,

[Your Signature]

[Your Printed Name]