



STERLING HSA®

475 14th Street,
Suite 650
Oakland, CA 94612

P.O. Box
71107
Oakland, CA 94612

T: 1.800.617.4729
F: 1.877.517.4729
www.sterlinghsa.com

Health Savings Account Request for Account Change

Accountholder _____

Sterling HSA Account # _____

| PLEASE CHANGE MY: | NEW CHANGES TO REFLECT ON MY ACCOUNT | | |
|---------------------------------------|--|----------------------------|----------------------------|
| <input type="checkbox"/> ADDRESS | | | |
| | Address | City | State Zip |
| <input type="checkbox"/> CONTACT INFO | | | |
| | Email Address | Work Telephone | Home Telephone |
| <input type="checkbox"/> NAME | | | |
| | First Name | Middle Initial | Last Name |
| <input type="checkbox"/> HEALTH PLAN | <input type="checkbox"/> Family Plan | \$ | |
| | <input type="checkbox"/> Individual Plan | | |
| | New Health Plan | Family or Individual Plan? | Deductible Amount |
| <input type="checkbox"/> FEE PLAN | <input type="checkbox"/> Standard Plan \$8.75 <input type="checkbox"/> Value Plan \$2.50 | | |
| | Change my monthly plan fee to: | | |
| <input type="checkbox"/> DEPENDENTS | <input type="checkbox"/> Add <input type="checkbox"/> Remove | | |
| | 1. | _____ | _____ |
| | 2. | _____ | _____ |
| | 3. | _____ | _____ |
| | | Name | Date of Birth Relationship |

Accountholder Signature _____

Date _____