

All fields of this form are required to be completed. Copies of completed form should be made and retained by both the employee and the employer.

Notice to Employer: Submit a completed form for each HSA Account Holder along with funds to be deposited no later than 2 ½ months after the end of the plan year to which the rollover applies. Please mail the original, signed copy of this form & check to:

Sovereign Bank HSA, P.O. Box 14387, Reading, PA 19612

By the authorized signature below, the successor (receiving) HSA/FSA/HRA/IRA Trustee/Custodian agrees to accept the transferred assets and to deposit them into an IRS-approved Health Savings Account.

Account Holder Contact Information:

Employee's Name		HSA Account Number		Phone	
Address		City		State	Zip
E-mail Address			Name of Employer		Phone

Distribution Selection:

Employer (named above) has informed me that my FSA or HRA account balance may be rolled over to my HSA pursuant to a qualified HSA distribution meeting the requirements of IRS Notice 2007-22. In this regard: i) the FSA or HRA was amended prior to the last day of the plan year to allow a qualified HSA distribution; ii) if the qualified HSA distribution is being made with respect to an FSA, the FSA has a grace period (i.e., 2 ½ month period after the end of the year in which to submit claims); iii) this election is being made prior to the last day of the plan year; iv) the health FSA or HRA makes no further reimbursements after the last day of the plan year. This form shall direct your Employer as to where rollover funds shall be deposited.

I understand that if my Health FSA or HRA balance is not zero after the qualified HSA distribution is made that I may be subject to adverse tax consequences unless the Employer has amended the Health FSA or HRA for all participants to be a limited purpose Health FSA or HRA as set forth in IRS Revenue Ruling 2004-45. I further understand that the qualified HSA distribution will be included in my income and subject to a 10% excise tax if I fail to satisfy the requirements to be an HSA eligible individual (as defined in Internal Revenue Code Section 223) during the month in which the qualified HSA distribution is made or any of the 12 months following that month.

- HRA Rollover** – Please rollover \$_____ (not to exceed the employee's account balance as of September 21, 2006, or if lesser the HRA account balance on the last day of the plan year) from my HRA account directly into my HSA at Sovereign Bank on this date:_____. Make the check payable to "Sovereign Bank, for the benefit of (name of participant), HSA". Mail the check and the original signed copy of this form directly to Sovereign Bank at the address noted above.
- FSA Rollover** – Please rollover \$_____ (not to exceed the employee's account balance as of September 21, 2006, or if lesser the FSA account balance as of the last day of the plan year) from my FSA account directly into my HSA at Sovereign Bank on this date:_____. Make the check payable to "Sovereign Bank, for the benefit of (name of participant), HSA". Mail the check and the original signed copy of this form directly to Sovereign Bank at the address noted above.

Please note, your financial institution may require a Medallion Signature Guarantee. Please check with them before you sign this form.

Account Holder Signature:

I hereby certify that I am eligible to establish or maintain an HSA and I understand that the qualified HSA distributions elected above will be mailed directly to Sovereign Bank at the address noted above.

I certify that, to the best of my knowledge, the information provided on this form is true and correct. Due to the important tax consequences of this transaction, I agree to seek the advice of a legal or tax professional, as needed.

Signature of Account Holder:_____