

Health Savings Account Power of Attorney Form

1. Complete all sections of this form.
2. **Signatures must be notarized.**
3. Email or mail completed form to:

Email: HSA@adminamerica.com

Address: 1720 Windward Concourse, Suite 290, Alpharetta GA 30005

*Required Fields

Part I Consumer Information		
*Consumer Name (First, MI, Last)	*Employer Name (If sponsored by an employer plan)	
*Birth Date (MM/DD/YYYY)	*Social Security Number	*Day Telephone

Part II Power of Attorney Designation		
* Attorney-in-fact Name (First, MI, Last)		
*Birth Date (MM/DD/YYYY)	*Social Security Number	*Day Telephone
*Address		
*City	*State	*Zip

Admin America, Inc. is hereby authorized to recognize the signature subscribed below in the payment of funds or transactions of any business for this account. All transactions shall be governed by applicable laws and the Health Savings Account Custodian Agreement. To the extent allowed by law, this authorization shall survive my disability or incapacity, and shall remain in effect until Admin America, Inc. receives written notice of revocation and a reasonable opportunity to act on such notice.

Signature	
By signing below, I authorize the attorney-in-fact identified above to perform any act I may perform pursuant to my HSA Custodial Agreement with Admin America, Inc. and WEX Inc. This Power of Attorney is effective upon my signing. This authorization includes, for example, the ability to: (1) endorse, cash, or deposit checks or other items payable to my order, (2) withdraw funds from this account via any means allowed for this account, including but not limited to checks, ACH and wire transfers; and (3) give instructions for the handling of any and all matters in connection with this account. I understand the powers I give to my attorney-in-fact, and any limitations on those powers are between the attorney-in-fact and me, even if Admin America, Inc. have express written notice of those powers. I agree to hold Admin America, Inc. and WEX Inc., harmless and be responsible for any damages or costs incurred due to my HSA Administrator's reliance on this Power of Attorney.	
*Signature of HSA Account Holder	*Date
*Signature of Attorney-in-fact	*Date
*Notary to complete	
Subscribed and sworn to before me this _____ day of _____, 20____	
Notary Public Signature: _____	

Revocation of Power of Attorney

I hereby revoke the appointment named Power of Attorney and have notified them of this change. I understand that Admin America, Inc. and WEX Inc. may charge the account for the amount of any check or pre-authorized transactions dated on or before this date if they have been authorized by my attorney-in-fact.

*Signature of HSA Account Holder

*Date

*Signature of Attorney-in-fact

*Date

*Notary to complete

Subscribed and sworn to before me this _____ day of _____, 20____

Notary Public Signature: _____