

Distribution Request for Health Savings Accounts (HSAs)

For GroupCare or Congregational Employee Plan

Mail this request to MMA, Attn: FlexChoice/HSA or fax to (574) 537-6642.

Please do **not** send copies of bills with this.

Employer _____

Account holder's name _____

Social Security number _____

Amount requested \$ _____

Distribution requests will all be withdrawn first from funds you have in the money market. If the amount you have requested is more than you have in your money market account, please tell us from which investment fund to withdraw the money. If you do not tell us where to take the money from, we will withdraw from the funds in the order they're listed below.

Intermediate Income. Amount \$ _____

Value Index. Amount \$ _____

Core Stock. Amount \$ _____

International Stock. Amount \$ _____

Account holder's signature _____ **Date** _____

Description for your records (Complete only if you want the doctor's name or date of visit on the check stub):



1110 North Main Street
Post Office Box 483
Goshen IN 46527

Toll-free: (800) 348-7468
Telephone: (574) 533-9511
www.mma-online.org

Office use only

Date received _____

Date processed _____

By _____

Check number _____

Date mailed _____