Limited-Purpose FSA Deductible Verification Form

Complete this form if you are enrolled in a Limited-Purpose Flexible Spending Account (LP-FSA) and have met your minimum, qualified IRS medical plan deductible for the current plan year.

Please return the completed form by email to hsaforms@hsabank.com, fax to 877-851-7041, or mail to P.O. Box 939, Sheboygan, WI 53082-0939.

For assistance, our U.S.-based Client Assistance Center has English and multilingual representatives available 24 hours a day, 7 days a week, at 1-800-357-6246.

When the minimum, qualified IRS medical plan deductible for your LP-FSA has been met for the current plan year, your account will be converted to a General-Purpose (or Post-Deductible) FSA. The General-Purpose FSA enables reimbursements for general medical expenses.

All fields are required.

Accountholder Information			
First Name:	MI:	Last Name:	
Date of Birth (mm/dd/yyyy):	Full Social Security Number:		
Mailing Address:	City:	State:	ZIP:
Phone Number:	Email Address:		
Employer Name:			

FSA Deductible Information	
Plan Year Start Date (mm/dd/yyyy):	Plan Year End Date (mm/dd/yyyy):
Date FSA Deductible Was Met (mm/dd/yyyy):	Deductible Amount: $

Accountholder Signature	
As the accountholder whose information appears above, I hereby certify that the information provided by me is accurate and I have met the IRS minimum deductible for my plan year.	
Accountholder Signature:	Date:

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