



HEALTHCARE ACCOUNT BENEFICIARY CHANGE REQUEST

Account Type: Idaho MSA HSA

Account Holder's Name: _____

Account Number or SSN: _____

In the event of my death, I name as my beneficiary:

Name: _____

Relationship: _____

To complete the above designations, Idaho Independent Bank will require account holders to sign a revised signature card or plan documentation, as applicable. A representative will contact you to obtain signature(s).

Account Holder's Signature

Date

Joint Account Holder's Signature

Date

Submit completed forms to Idaho Independent Bank
Fax: (208) 947-1159 or
Email: HealthcareAccounts@iibk.net

800-897-4863
HealthcareAccounts@iibk.net
www.theidahobank.com

