BENEFICIARY FORM
FOR HEALTH SAVINGS ACCOUNTS

##94T02113##################

A. PARTICIPANT INFORMATION (REQUIRED – COMPLETE IN FULL)

Name:_____ DMBA ID number: _____
FIRST MIDDLE INITIAL LAST

Birth date (MM/DD/YYYY): _____ Email: _____

Mobile/Primary phone: _____ Alternate phone:_____

Marital status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced Sex: ☐ Male ☐ Female

Spouse name and birth date: _____

B. PARTICIPANT AUTHORIZATION (REQUIRED)

Signature: _____ Date: _____

C. IMPORTANT INFORMATION TO KNOW WHEN NAMING YOUR BENEFICIARIES

- Types of Beneficiaries
  - » Primary: Person to receive benefits when you die.
  - » Alternate: Person to receive benefits when you die if the primary beneficiary is deceased.
- If you name multiple primary or multiple alternate beneficiaries, benefits will be split equally, unless otherwise noted on the form. If you're allocating the percentage of benefit, please verify that the total for primary beneficiaries equals 100% and the total for alternate beneficiaries equals 100%.
- If you name minor children as beneficiaries, we must have legal guardianship papers for each child at the time of your death if they are unmarried and younger than 18. This could mean legal expenses for the beneficiary and delay benefit payments. Please consider this when naming your beneficiaries.
- When you die, DMBA will contact your primary beneficiary to request additional information, including a death certificate.

D. BENEFICIARY DESIGNATION

LIST ALL BENEFICIARIES: Beneficiary payments are paid from the most recent, valid beneficiary designation. Name all beneficiaries or designate a trust as a beneficiary.

BENEFICIARY DESIGNATION (list beneficiaries or designate trust):

☐ All primary beneficiaries share equally
☐ All alternate beneficiaries share equally

DESIGNATION (REQUIRED)	FULL GIVEN NAME OF BENEFICIARY (REQUIRED)	SOCIAL SECURITY # (REQUIRED)	RELATIONSHIP (REQUIRED)	BIRTH DATE (REQUIRED)	PHONE # (REQUIRED)	% OF BENEFIT
☐ PRIMARY ☐ ALTERNATE						
☐ PRIMARY ☐ ALTERNATE						
☐ PRIMARY ☐ ALTERNATE						
☐ PRIMARY ☐ ALTERNATE						
☐ PRIMARY ☐ ALTERNATE						

DESIGNATION (REQUIRED)	NAME OF TRUST (REQUIRED)	DATE OF TRUST (REQUIRED)	PHONE # (REQUIRED)	% OF BENEFIT
☐ PRIMARY ☐ ALTERNATE				

Please return this completed form to enrollmenthelp@dmba.com. You may also mail it to DMBA, Attention: Member Services, P.O. Box 45530, Salt Lake City, UT 84145-0530 or fax it to 801-578-5933. For questions, visit www.dmba.com or call us at 801-578-5600 or 800-777-3622.