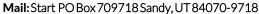
Beneficiary Designation Form

Email or Mail completed forms to: Email: support@starthealth.com





Note: If you are married and living in a community property state (AK, AZ, CA, ID, LA, NV, NM, TX, WA, WI), and you want to designate a primary beneficiary other than your spouse, your spouse must agree in writing to your designation and you must submit a physical copy of this form by mail or fax. You should consult your legal/tax advisor when completing this form, as there may be tax and/or legal consequences to your designation. You have the option to list one or more persons to be the primary and contingent beneficiaries for your HSA (including your estate or a trust) as applicable. If designating multiple primary or contingent beneficiaries, indicate the percentage share each should receive, ensuring the total of each adds up to 100%. Designations are effective upon receipt by MotivHealth and unless otherwise specified, cancel all previous HSA beneficiary designations on file.

| Account Holder Information (all fields are required) | | | | | |
|--|------------------------------|---------------------------|----------------------------|--|--|
| Last Name | First Name | | M.I. | | |
| E-Mail Address | Daytime Phone | SSN or MotivHealth ID Num | ber (6 or 7 digits) | | |
| Primary Beneficiary(ies) | | | | | |
| To ensure timely completion of your request, please complete a | II fields for each beneficia | ary you designate. | | | |
| Primary Beneficiary 1 Estate/Trust Yes No | | | | | |
| Name | | SSN or TIN | Date of Birth (mm/dd/yyyy) | | |
| Address | City | State | ZIP | | |
| Relationship | | | Percent % | | |
| Primary Beneficiary 2 Estate/Trust Yes | No | | | | |
| Name | | SSN or TIN | Date of Birth (mm/dd/yyyy) | | |
| Address | City | State | ZIP | | |
| Relationship | | | Percent % | | |
| Primary Beneficiary 3 Estate/Trust Yes No | | | | | |
| Name | | SSN or TIN | Date of Birth (mm/dd/yyyy) | | |
| Address | City | State | ZIP | | |
| Relationship | | | Percent % | | |
| Primary Beneficiary 4 Estate/Trust Yes | No | | | | |
| Name | | SSN or TIN | Date of Birth (mm/dd/yyyy) | | |
| Address | City | State | ZIP | | |
| Relationship | | | Percent % | | |
| | | | | | |

| Contingent beneficiaries receive your HSA assets in the event that all of your primary beneficiaries pass away before you. | | | | |
|--|------|------------|----------------------------|--|
| Contingent Beneficiary 1 Estate/Trust Yes N | 0 | | | |
| Name | | SSN or TIN | Date of Birth (mm/dd/yyyy) | |
| Address | City | State | ZIP | |
| Relationship | | | Percent % | |
| Contingent Beneficiary 2 Estate/Trust Yes N | 0 | | | |
| Name | | SSN or TIN | Date of Birth (mm/dd/yyyy) | |
| Address | City | State | ZIP | |
| Relationship | | | Percent % | |
| | | | Total 100% | |
| Authorization | | | | |
| Participant Signature Name (please | | |)ate | |

If you're a resident of a community or marital property state and have designated a beneficiary other than, or in addition to, your spouse, have your spouse authorize the designation by signing below.

Spousal Consent: I am the legal spouse of the HSA account holder. I acknowledge that I have received a fair and reasonable disclosure of my spouse's property and financial obligations. Due to the tax consequences of giving up my interest in this HSA, I have been advised to see a qualified tax professional. I hereby consent to the beneficiary designation(s) indicated above.

Date

Name (please print)

Contingent Beneficiary(ies)

Spouse's Signature

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