HSA Change of Personal Information Form

Mail or fax completed forms to:

Address: **American Health Value**
PO Box 8063, Boise, ID 83707-2063

Fax: 208.331.2651

Email: info@AmericanHealthValue.com

HSAs Done Right!

Use this form to update/change your personal information on file with American Health Value.

Primary Account Holder Information (Please complete all fields)

Old	Last Name	First Name		M.I.	Date of Birth
	Street Address	City	State		ZIP
	E-mail Address (required)	Daytime Phone ( )	Last 4 of SSN		

Information to Update (Please complete the fields you would like updated on your account)

New	Last Name	First Name		M.I.	Date of Birth
	Street Address	City	State		ZIP
	E-mail Address (required)	Daytime Phone ( )	SSN		

Important: Additional Documentation May Be Required

Address Verification (when changing the address on file and requesting a new card)

The Red Flag Rule is a Federal Law set up to protect account holders from fraudulent activity on their account. Specifically, when an address is changed and a new card is requested. To protect our members in this situation, we ask that you please attach a copy of an address verification document such as a utility bill, a paystub, a bank statement (except your American Health Value statement), a driver's license or a state issued identification card; anything printed that has the account holder name and new address.

Name Change

To request a name change, please attach a copy of Marriage License, Divorce Decree, W2 or Social Security Card.

Date of Birth Correction

To correct the DOB we have on file which we use for account authentication purposes, please attach a copy of Driver's License or State Issued ID card, Passport or Birth Certificate.

Social Security Number Correction

To correct the SSN we have on file which is used for tax reporting and account authentication purposes, please attach a copy of a W2 or Social Security Card.

New Card Request Authorization

For address verification or name change, if also requesting a new card, please initial here. Note: Please destroy your old card as it will be permanently deactivated upon request of a new card.	Initials

Change of Personal Information Authorization

By signing below, I authorize American Health Value to update and change my personal account information which will be used for account authentication, sending account correspondence and tax reporting purposes.
I assume complete responsibility for ensuring that all of my personal information is correct and up to date.

Name (please print)	Signature	Date

Please allow 2-3 business days to process your form. If a new card is requested, please allow an additional 7-10 business days for delivery.