Fenyx Health

BENEFICIARY DESIGNATION FORM

CLEAR THIS FORM

Complete this form and send to us at:

Secure Upload: go.fenyxhealth.com/securefileupload

Mail: Fenyx Health, Attn: MSA Custodian
PO Box 135, Winfield, PA 17889

You should consult your legal/tax advisor when completing this form, as there are different tax consequences based on the designated beneficiary of the Account. See IRS Publication 969 and the IRS Instructions for Form 8853, available at www.irs.gov.

Fenyx Health does not provide legal and/or tax advice.

If married, living in a community property state and want to designate a primary beneficiary other than your spouse, your spouse must agree in writing to your designation. Then, submit a physically signed (not electronically typed) copy of this form by secure upload or mail.

If your surviving spouse is the designated beneficiary, the Medicare Advantage MSA is treated as a regular Archer MSA (not a Medicare Advantage MSA) of the surviving spouse for distribution purposes, less any Health Plan-owed liabilities and any reasonable fees, expenses or other charges we believe necessary to transition the Account.

If the designated beneficiary isn't your surviving spouse, or there is no designated beneficiary, the Account ceases to be an MSA as of the date of death and is liquidated, less any Health Plan-owed liabilities and any reasonable fees, expenses or other charges we believe necessary to close the Account. The fair market value is taxable to the beneficiary/your estate in the tax year of your death.

Unclaimed property laws may require us to turn over any MSA funds, less any Health Plan-owed liabilities and any reasonable fees, expenses or other charges we believe necessary to close the Account, that are considered abandoned by an applicable state (generally the state in which you reside or have listed as the residential address for your MSA).

MSA beneficiary designations are effective upon receipt by Fenyx Health and, unless otherwise specified, cancel all previous MSA beneficiary designations on file.

Please complete all sections of this form. Missing or incorrect information can delay the processing of your form and/or prevent timely distribution to beneficiaries in the event of your passing.

1 — Account Holder Information

First name*	Last name*	
Fenyx Health member ID number*	Email address*	Daytime phone*

Form continues on the next page

2 — Primary Beneficiary

Estate/Trust? ☐ Yes ☐ No

Name*	SSN or TIN*	Date of Birth (mm/dd/yyyy)	
Mailing address*	City*	State* Select...	Zip code*
Relationship*			

A contingent beneficiary receives your MSA assets in the event that your primary beneficiary passes away before you.

3 — Contingent Beneficiary

Estate/Trust? ☐ Yes ☐ No

Name*	SSN or TIN*	Date of Birth (mm/dd/yyyy)	
Mailing address*	City*	State* Select...	Zip code*
Relationship*			

4 — Spousal Consent: For Community/Marital Property States

This section should be reviewed if you reside in a community/marital property state. Due to important tax consequences of giving up one's community property interest, you and your spouse should consult with your tax or legal professional(s).

☐ **I am married and spouse is listed as primary beneficiary:** Skip to Section 5.

☐ **I am married and spouse is not listed as primary beneficiary:** Spouse physically signs Section 4.

☐ **I am not married:** Skip to Section 5. File a new form if you marry in the future.

Spousal consent: I am the legal spouse of the MSA account holder. I acknowledge I have received a fair and reasonable disclosure of my spouse's property and financial obligations, and have been advised to see a qualified tax or legal professional. I hereby give the account holder any interest I have in the Account funds or property, consent to the designations indicated above and assume full responsibility for any adverse consequences that may result.

Spouse's signature*	Date*

5 — Authorization

I authorize Fenyx Health Insurance Company to act upon the above information and certify the information is true and complete. I understand this designation a) is subject to all the terms and provisions listed above plus any applicable state or federal law or regulations, b) shall be effective only if received by Fenyx Health prior to my passing and c) applies to my entire interest in the Account.

Account holder signature*	Date*