BenefitWallet

Additional Signature Authorization Form – Medical Savings Account
The Bank of New York Mellon

Name (1): _____ Account Number: _____

SSN: _____ Date: _____

By submitting this form, you are hereby granting the person designated below (i.e., your secondary signer) the ability to write checks against your Medical Savings Account, and to make withdrawals from your Medical Savings Account. Please fill-in the secondary signer's information below, sign box 1 (granting authorization), and have the second signer sign in box 2.

First Name (2): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Last Name (2): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Authorized Signature(s) **REQUIRED** to process this form.

1. _____

Account Holder's signature granting authorization

2. _____

Secondary signer's signature

Please provide the following information for the secondary signer designated above:

Street Address: _____

City: _____ State: _____ Zip: _____

Important:

- ✓ Return the completed form by **mail** to BenefitWallet, P.O. Box 5212, Cherry Hill, NJ 08034, or by **Courier/Overnight** by sending to BenefitWallet, 101 Woodcrest Road, Cherry Hill, NJ 08003-3620.

Secondary