Distribution of Excess HSA Contribution Form

HealthEquity®

Mail or fax completed forms to:

Address: **HealthEquity, Attn: Client Services**
PO Box 14374 Lexington, KY 40512

Fax: 520.844.7090

Primary Account Holder Information

Employer Name (if applicable)			
Last Name	First Name		M.I.
Street Address	City	State	ZIP
E-Mail Address	Daytime Phone ( )	Last 4 of SSN or HealthEquity ID Number (6 or 7 digits)	

Excess Contribution Information

Excess contribution amount:_____ Tax year:_____

This form is required to correct amounts contributed in excess of your contribution limit for the year. Refer to www.ustreas.gov for the HSA contribution limits applicable for each tax year. Please contact HealthEquity Member Services at 866.346.5800 for assistance.

The amount contributed in excess of your contribution limit is subject to a penalty tax unless the excess and interest earned are withdrawn prior to the due date, including any extensions, for filing your federal income tax return.

Please note: A $20.00 processing fee may apply and will be reduced from the amount returned. There must be sufficient funds in your account to cover the distribution of an excess contribution and any interest earned on excess contributions.

Banking Information

How would you like the funds distributed? Please check one.

☐ **Option 1—Change tax year to:** _____ (Contribution will count toward your yearly contribution maximum.)

☐ **Option 2—Check (default)**

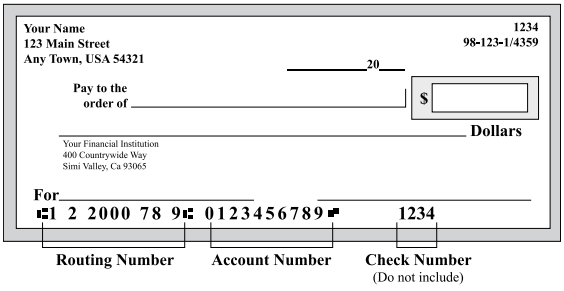
☐ **Option 3: One-time electronic funds transfer (EFT)**

Financial institution:_____

Routing number:_____

Account number:_____

(Form must be accompanied by a copy of a voided or an actual check)



Authorization

By signing below, I swear or affirm that the deposit in the amount stated above is repayment of a mistaken contribution(s) as defined by the Internal Revenue Service to my HSA resulting from a mistake of fact due to reasonable cause. I understand that I am solely responsible for any tax consequences and penalties of improper reporting of this deposit as repayment of a mistaken distribution, instead of a contribution, to my HSA.

Name (please print)	Signature	Date

Note: Incomplete forms will not be processed. In such cases, we will attempt to contact you via email or phone to advise that the form was missing information.