HSA Contribution Form

HealthEquity®

Mail or fax completed forms to:

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

Fax: 801.727.1005

Primary Account Holder Information

Employer Name			
Last Name	First Name		M.I.
Street Address	City	State	ZIP
E-Mail Address (required)	Daytime Phone ( )	SSN or HealthEquity ID Number	

Contributions

Contribution tax year:_____	Contributions for the prior tax year are accepted until Tax Day of the following year. Funds will be applied to the tax year of the date on the attached check if no year is indicated.

Banking Information

What method would you like to use to make contributions to your HSA?

☐ **Option 1—Check**

Include a check payable to HealthEquity with this form and mail to:

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

Include the **tax year** and your **HealthEquity ID number** (6 or 7 digits) on the check.

When you provide a check as payment, you authorize HealthEquity to either use the information from your check to make a one-time, Back Office Conversion (BOC), electronic fund transfer from your account if eligible, or to process the payment as a check transaction. Funds processed via BOC may be withdrawn from your account as soon as the same day your payment is received.

☐ **Option 2**—One-time electronic funds transfer (EFT)

Fax this form and a copy of a voided check to:
HealthEquity, Attn: Member Services, 801.727.1005.

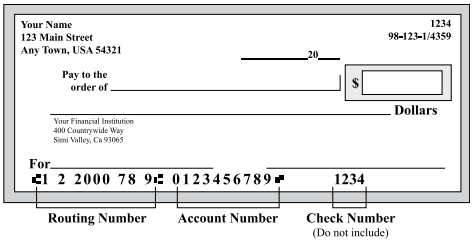
Account type: ☐ Checking ☐ Savings Amount of deposit: $_____

Financial institution:_____

City/state:_____

Routing number:_____ Account number:_____

Voided check is required if your personal account is not on file.



☐ **Option 3—Recurring monthly electronic funds transfer (EFT)**

Fax this form and a copy of a voided check to HealthEquity, Attn: Member Services, 801.727.1005. Voided check is required if your personal account is not on file.

Amount of deposit: $_____ Day of month funds should be pulled:_____

Financial institution:_____ City/state:_____

Account type: ☐ Checking ☐ Savings Routing number:_____ Account number:_____

Authorization

By signing below, I authorize the deposit of the above stated amount into my HealthEquity health savings account (HSA).
I understand the eligibility requirements of the type of HSA deposit I am making and state that I qualify to make the deposit.

I assume complete responsibility for:

1. Determining that I am eligible for an HSA each year I make a contribution.
2. Ensuring that all contributions I make are within the limits set forth by tax laws.
3. The tax consequences of any contribution (including rollover contributions) and distributions.

Name (please print)	Signature	Date

Please allow three to five business days after your form is processed by HealthEquity for your deposit to post to your account.