Mistaken HSA Distribution Form

HealthEquity®

Mail or fax completed forms to:

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

Fax: 801.999.7829 (cover sheet not required)

Primary Account Holder Information

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

Distribution Information

Amount of mistaken distribution: $_____ Year of mistaken distribution:_____

I certify that the above distribution was the result of a mistake of fact and I authorize HealthEquity to redeposit the distribution as a mistaken distribution.

I understand HealthEquity is not required to accept the mistaken distribution and, that I am responsible for any tax consequences that may result from the distribution.

Banking Information (If no option is selected, form is void)

☐ **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

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 Funds processed via BOC may be withdrawn from your account as soon as the same day your payment is received.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 —** Use verified EFT account already on file associated to my HSA. Please provide last 4 of account number_____.*

Note: Account must be verified for contributions in order for HealthEquity to pull the funds via EFT.

☐ **Option 3 —** One-time electronic funds transfer (EFT). **(Form must be accompanied by a copy of a voided or an actual check)**

*Required fields

Signature

By signing below, I swear or affirm that this deposit, in the amount stated above, to my health savings account (HSA) is repayment of a mistaken distribution or distributions as defined by the Internal Revenue Service (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.