

# Mistaken HSA Distribution Form



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, 15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020

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 Funds processed via BOC may be withdrawn from your account as soon as the same day your payment is received.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.**