

# Mistaken HSA Distribution Form

Mail or fax completed forms to:

**Address:** HealthEquity, Attn: Client Services  
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020

**Fax:** 520.844.7090

# HealthEquity®

Building Health Savings™

## 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 Funds processed via BOC may be withdrawn from your account as soon as the same day your payment is received.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—One-time electronic funds transfer (EFT)**

Fax this form and a copy of a voided check to:  
HealthEquity, Attn: Client Services, 520.844.7090.

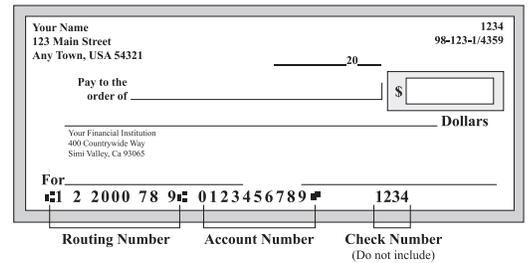
Account type:  Checking  Savings Amount: \$ \_\_\_\_\_

Financial institution: \_\_\_\_\_

Routing number: \_\_\_\_\_ Account number: \_\_\_\_\_

**Form must be accompanied by a copy of a voided or an actual check.**

**Option 3—Use the verified EFT account already tied to my HSA.**



## 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
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