

## Distribution Reversal Form

**Instructions:** Please mail this completed form with a check for the amount of the distribution to be reversed to:

**HSA Bank, P.O. Box 939, Sheboygan, WI 53082-0939**

For assistance, please call (800) 357-6246, Monday - Friday, 7 a.m. - 9 p.m., CT.

### ACCOUNTHOLDER INFORMATION:

First Name:	MI:	Last Name:
Street Address:		
City:	State:	ZIP Code:
Account Number (8 digits from your Welcome Kit or statement)	Social Security Number	
<input type="text"/>	<b>OR</b> <input type="text"/> - <input type="text"/> - <input type="text"/>	

### DISTRIBUTION INFORMATION:

Distribution Reversal Amount:	Original distribution occurred in:
\$ <input type="text"/>	<input type="checkbox"/> Current Year <input type="text"/> (yyyy)
	<b>OR</b>
	<input type="checkbox"/> Prior Year <input type="text"/> (yyyy)

Please indicate the reason you are requesting to reverse a distribution.

- A claim/distribution was overpaid and I authorize HSA Bank to redeposit the overpayment.
- A distribution was withdrawn in error and I authorize HSA Bank to redeposit the amount.

**NOTE:** Distribution reversals must be deposited to your account by the tax-filing deadline for the year in which the original distribution occurred (typically April 15 of the following year), NOT including extensions. If no year is specified, your distribution reversal will be deposited for the year in which it was received.

### SIGNATURES

By my signature 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.

Signature:	Date:
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