Health Savings Account (HSA) Distribution Reversal Form

hsabank
A Division of Webster Bank, N.A., Member FDIC

Instructions: Please mail this completed form with a check for the amount of the distribution to be reversed to:
Regular Mail: HSA Bank, P.O. Box 939, Sheboygan, WI 53082-0939
Overnight Mail: HSA Bank, 605 North 8th Street, Suite 320, Sheboygan, WI 53081
For assistance, call 800-357-6246 any time.

Accountholder Information

First Name:	MI:	Last Name:
Street Address:		
City:	State:	ZIP Code:
Account Number (8 or 12 digits from your statement or Member Website):		

OR

Full 9-digit Social Security Number:				-			-				

Account Number OR full Social Security number is required.

Distribution Information

Distribution Reversal Amount: $_____	Date That Original Distribution Occurred (mm/dd/yyyy):

Please indicate the reason that 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- ☐ A distribution was withdrawn in error and I authorize HSA Bank to redeposit the amount.
- ☐ My account was closed by HSA Bank due to lack of verified identification but is now open and I authorize HSA Bank to redeposit the full amount.

NOTE: HSA Bank will reverse only distributions that occurred in the current year or the previous year. If no year is specified, your distribution reversal will be deposited for the year in which it was received.

Signature

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.

Accountholder Signature (Required):	**Date:**