# Health Savings Account (HSA) Distribution Reversal Form

**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, Monday - Friday, 7 a.m. - 9 p.m., or Saturday, 9 a.m. - 1 p.m., CT.
Para ayuda en Español, por favor llamar 866-357-6232.

| ACCOUNTHOLDER INFORMATION: | | |
|---|---|---|
| First Name: | MI: | Last Name: |
| Street Address: | | |
| City: | State: | ZIP Code: |
| Account Number (8 or 12 digits from the Member Website): | | |
| **OR** | | |
| Accountholder's Full Social Security Number: ____________-________-_________________ | | |
| *Account Number OR full Social Security Number is required.* | | |

| DISTRIBUTION INFORMATION: | |
|---|---|
| Distribution Reversal Amount: $________________.________ | Date Original Distribution Occurred (mm/dd/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☐ A distribution was withdrawn in error and I authorize HSA Bank to redeposit the amount.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 no later than April 15th following the first year you knew or should have known the distribution was a mistake. 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 (required):** | **Date:** ________/________/_________________ |
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