



MISTAKEN DISTRIBUTION REPAYMENT

PART 1. HSA OWNER

Name (First/MI/Last) _____
 Social Security Number _____
 Date of Birth _____ Phone _____
 Email Address _____
 Account Number _____ Suffix _____

PART 2. HSA TRUSTEE OR CUSTODIAN

To be completed by the HSA trustee or custodian

Name _____
 Address Line 1 _____
 Address Line 2 _____
 City/State/ZIP _____
 Phone _____ Organization Number _____

PART 3. REPAYMENT INFORMATION

A mistaken distribution occurs when an HSA owner takes an HSA distribution that was mistakenly believed to be qualified.

A distribution may only be returned as a mistaken distribution if deposited no later than April 15 of the year following the year it was determined to be a mistaken distribution.

1. Returned Mistaken Distribution Amount _____
2. Original Distribution Date _____
3. Repayment Date _____

PART 4. INVESTMENT AND DEPOSIT INFORMATION

INVESTMENT INFORMATION *(Complete this section as applicable.)*

Investment Description	Quantity or Amount	Status <i>(new or existing)</i>	Investment Number	Term or Maturity Date	Interest Rate
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

DEPOSIT METHOD

Cash or Check

Internal Account

Account Number _____ Type (e.g., checking, savings) _____

External Account (e.g., EFT, ACH, wire) *(Additional documentation may be required and fees may apply.)*

Name of Organization Sending the Assets _____ Routing Number (Optional) _____

Account Number _____ Type (e.g., checking, savings) _____

Deposit Taken by _____

PART 5. SIGNATURES

I certify that all of the information provided by me is accurate and may be relied upon by the trustee or custodian. I certify that the deposit described above qualifies as a repayment of a mistaken distribution and I authorize the deposit/investment in the manner indicated. All decisions regarding this deposit are my own, and I expressly assume responsibility for any consequences that may arise from this deposit. I agree that the trustee or custodian is not responsible for any consequences that may arise from processing this transaction.

X _____
Signature of HSA Owner

_____ Date (mm/dd/yyyy)

X _____
Signature of Trustee or Custodian

_____ Date (mm/dd/yyyy)