Health Savings Account (HSA)
Tax Correction Form

hsabank A Division of Webster Bank, N.A., Member FDIC for cigna healthcare

Instructions: Please complete all sections and sign this form.
Return the completed form to HSA Bank by mail to HSA Bank, P.O. Box 939, Sheboygan, WI 53082; email to hsaforms@hsabank.com; or fax to 877-851-7041.

You can review your transactions on your statement or through myCigna® and the HSA Bank link. If you need assistance, please call the number on the back of your ID card.

Note: Your request can be processed only if it is within the regulatory limitations. If your request is not within those limitations, it will be rejected. For information regarding limitations, you may visit IRS.gov or consult with your tax advisor.

Accountholder Information		
First Name:	Middle Initial:	Last Name:
Street Address:		
City:	State:	ZIP Code:
Account Number (8 or 12 digits from your statement or on myCigna®):		
Full 9-digit Social Security Number:		

Recode the following contributions. *At least one selection must be made below. If there are more than two transactions, please supply a spreadsheet with the data.*	
Transaction Date:	**Amount:**
Tax year	☐ Change to current year ☐ Change to prior year
Contribution type	☐ Post-tax contribution ☐ Payroll deduction ☐ Employer contribution
Reimbursement	☐ From distributions ☐ From provider or insurance
Rollover	☐ From HSA ☐ From IRA
Transaction Date:	**Amount:**
Tax year	☐ Change to current year ☐ Change to prior year
Contribution type	☐ Post-tax contribution ☐ Payroll deduction ☐ Employer contribution
Reimbursement	☐ From distributions ☐ From provider or insurance
Rollover	☐ From HSA ☐ From IRA

Authorization ***(Either the accountholder or the employer must authorize the tax correction.)***	
☐ **Accountholder:** By signing below, I authorize HSA Bank to update the above contribution(s) on my Health Savings Account to correct the contribution error. If the error occurred last year, I understand that I may receive corrected tax forms and should consult with a tax advisor.	
Accountholder Signature:	Date:
☐ **Employer:** By signing below, I authorize HSA Bank to update the above contribution(s) on the Health Savings Account to correct the contribution error. If the error occurred last year, I understand that the accountholder may receive corrected tax forms and should consult with a tax advisor.	
Employer Signature:	Date: