Health Savings Account (HSA)
Contribution Reversal Form

Complete this form to request a reversal of contributions from your Health Savings Account (HSA). Please return this form to HSA Bank by email to hsaforms@hsabank.com, fax to 877-851-7041, or mail to HSA Bank, P.O. Box 939, Sheboygan, WI 53082-0939.

You can review your transactions via your statement or myCigna® (24/7 access). For assistance, please call the number on the back of your card.

Section A – Accountholder Information

First Name:	MI:	Last Name:
Mailing Address:		
City:	State:	ZIP Code:
Account Number (8 or 12 digits from your statement or on the Account tab on myCigna®):		

OR

Full 9-digit Social Security Number:				-			-				

Account Number OR full Social Security number is required.

Section B – Eligibility

Was the accountholder ever eligible for this HSA?

☐ Yes, please complete section C.

☐ No, accountholder was NEVER eligible for this HSA; all contributions will be removed and account will be closed.

***If any distributions occurred on the account, all distributed funds must be returned with this form to complete the request.**
***If the account is/was tied to investments or if funds were received via transfer to this account, this option cannot be selected. Section C must be completed to process this reversal.**

Section C – Contribution Reversal Details - If your request includes reversals for different tax years, complete one line below for each tax year

Reverse a total of $_____ in contribution(s) made in _____ tax year that is applied to _____ tax year

Reverse a total of $_____ in contribution(s) made in _____ tax year that is applied to _____ tax year

***Prior year reversals cannot be processed after the current year tax deadline has passed.**
***If the requested amount is greater than the available balance, only the available balance will be reversed.**

Section D – Contribution Correction Requested by

☐ Accountholder (If selected, funds will be sent to the accountholder; please disregard section E.)

☐ Employer **(If selected, Section E must be accurately completed AND signed for funds to be sent to the employer. If incomplete or inaccurate, funds will default to the accountholder.)**

Accountholder Signature: By signing below, I authorize HSA Bank to reverse the above contribution(s) from my Health Savings Account to correct the contribution error and return the funds. I understand that by completing this form, the contribution(s) will be reversed from my account if the account has a sufficient balance, and that the contribution(s) will not be included on tax reports if the error occurred this year. However, if the balance of the amount is not enough to cover the request, only the available amount will be processed. If the error occurred last year, I understand that I may receive corrected tax forms and that I should consult with a tax advisor.

Accountholder Signature:	Date:

Section E – Employer Information: * Section must be fully completed for funds to be returned to Employer.

Employer Name:

Attention to (Optional):

***FUNDS WILL BE MAILED TO THE EMPLOYER ADDRESS ON FILE.**

Employer Signature: By signing below, I authorize HSA Bank to reverse the above contribution(s) from the accountholder's Health Savings Account to correct contributions made in error. I understand that by completing this form, the contribution(s) will be reversed from the account if the account has a sufficient balance, and that the contribution(s) will not be included on tax reports if the error occurred this year. However, if the balance in the account is not enough to cover the request, only the available amount can be processed. If the error occurred last year, I understand that the accountholder may receive corrected tax forms and that he or she should consult with a tax advisor. **If the accountholder has not signed this form, I attest that the reason for submission is due to a verifiable administrative error within the IRS guidelines.**

Employer Signature:	Date: