# HSA MISTAKEN DISTRIBUTION REPAYMENT

EECU

## 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 *(new or existing)* | Investment Number | Term or Maturity Date | Interest Rate |
|---|---|---|---|---|---|
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### 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)*