

Distribution of excess HSA contribution form



EMAIL, FAX or MAIL COMPLETED FORMS TO:

Email: hsaoperations@motivhealth.com **Fax:** 844.533.1289

Mail: MotivHealth, Attention: HSA Operations
PO Box 709718 Sandy, UT 84070-9718

Primary account holder information			
Employer name (if applicable)			
Last name	First name		M.I.
Street address	City	State	ZIP
E-mail address	Daytime phone ()	Last 4 of SSN or MotivHealth ID number (6 or 7 digits)	

Excess contribution information	
Excess contribution amount: _____	Tax year: _____
<p>This form is required to correct amounts contributed in excess of your contribution limit for the year. Refer to www.ustreas.gov for the HSA contribution limits applicable for each tax year. Please contact MotivHealth Member Services at 844.234.4472 for assistance.</p> <p>The amount contributed in excess of your contribution limit is subject to a penalty tax unless the excess and interest earned are withdrawn prior to the due date, including any extensions, for filing your federal income tax return.</p> <p>Please note: This form will NOT lower your contribution totals for the year. A \$20.00 processing fee may apply and will be reduced from the amount returned. There must be sufficient funds in your account to cover the distribution of an excess contribution and any interest earned on excess contributions.</p>	

Banking information	
Select only one option. If no option is selected, or if there is no verified EFT account on file, a check will be mailed.	
Option 1—Change tax year to: _____ (Contribution will count toward your yearly contribution maximum.)	
<p>Option 2—One-time electronic funds transfer (EFT)</p> <p>Financial Institution: _____</p> <p>Routing Number: _____</p> <p>Account Number: _____</p> <p>(Form must be accompanied by a copy of a voided or an actual check)</p>	<p>Your Name 123 Main Street Any Town, USA 54321</p> <p>1234 98-123-1/4359</p> <p>_____ 20____</p> <p>Pay to the order of _____ \$ _____ Dollars</p> <p>Your Financial Institution 400 Countrywide Way Simi Valley, Ca 93065</p> <p>For _____</p> <p>⑆ 1 2 2000 78 9⑆ 0123456789 ⑆ 1234</p> <p>Routing Number Account Number Check Number (Do not include)</p>
Option 3—Check (default)	

Authorization		
By signing below, I swear or affirm that the deposit in the amount stated above is repayment of a mistaken contribution(s) as defined by the Internal Revenue Service to my HSA 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.		
Name (please print)	Signature	Date

Note: Incomplete forms will not be processed. In such cases, we will attempt to contact you via email or phone to advise that the form was missing information.