Health Savings Account (HSA) Distribution Request Form

Employee Data

Company Name:

Employee Name:

Last 4 of SSN/Participant ID:

Reimbursement Request

Normal/Disability/Prohibited Transaction Distribution

☒ Normal – For payment of qualified medical expenses; save your receipts

Disability – If the disability renders you unable to engage in any substantial gainful activity and it is medically determined that the conditional will last continuously for at least 12 months or lead to your death. Disability distributions are subject to ordinary income tax.

☐ Prohibited Transaction – use of HSA funds for anything other than a qualified medical expense; if not corrected in a timely manner, IRS penalties may be imposed.

Amount of Distribution $_____

Contribution Corrections

Excess Contribution Removal*: This option will take effect against the current year and will not generate new tax documents for the prior tax year.*

Amount of excess contribution $_____

Contribution Reversal: *Contributions made via your payroll will require coordination with your employer.*

Contribution Date _____

Amount to reverse $_____

Rollover/Transfer

If I am requesting account closure, I authorize the HSA Administrator to liquidate the investments in my HSA Investment Account and wait 10 days to allow any outstanding debit card transaction (if debit card is applicable to my account) to settle before mailing the check for any remaining account balance, less any applicable account closing fee.

☐ Rollover – Check will be made payable to HSA Accountholder and mailed to your address on file.

Please liquidate ☐ my entire account balance **or** ☐ $_____

This rollover ☐ will / ☐ will not close my HSA account (please check one).

The IRS Code limits the number of rollovers that may be taken, how quickly rollovers must be completed and how the trustee or custodian must report the transaction. If you need additional information, please contact your tax advisor. By selecting this option, you are certifying to the bank that you have satisfied the rules and conditions applicable to your rollover and that you are making an irrevocable election to treat the transaction as a rollover. The funds you receive from the distribution of an HSA must be deposited into another HSA within 60 days from when you receive them. You are entitled to one distribution per year per HSA which may be rolled over. You are entitled to roll over the same assets only once in a twelve (12) month period.

Verification

I certify that I am the HSA Account holder or an individual authorized to execute this transaction. I have read and understand the instructions and any rules or conditions relating to this transaction. I assume full responsibility for this transaction and will not hold HSA Administrator or Healthcare Bank, a division of Bell Bank Trust liable for any adverse consequences that may result. I have not received tax or legal advice from HSA Administrator or Healthcare Bank and, if necessary, will seek the advice of a tax or legal professional to ensure my compliance with related laws. All information provided by me is true and correct and may be relied upon HSA Administrator and Healthcare Bank.

Date **HSA Accountholder Signature**

New Phone/Address (Complete Only if Needed)

New Email Address:

New Home Address:

Online:
www.vitaflex.net

Fax:
Vita Flex Claims Dept.
(650) 964-FLEX (3539)
(866) 964-FLEX (3539)

E-mail:
help@vitamail.com

Mail:
Vita Flex
1451 Grant Road, #200
Mountain View, CA 94043