



### Employee Data

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Company Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Employee ID (Last 4 of SSN): \_\_\_\_\_

### Reimbursement Request

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#### Normal/Disability/Prohibited Transaction Distribution

- Normal - For payment of qualified medical expenses; save your receipts
- 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 \$ \_\_\_\_\_

#### Excess Contribution Removal

- Excess Contribution Removal

Amount of excess contribution \$ \_\_\_\_\_

Date excess contribution occurred \_\_\_\_\_

### Verification

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I certify that I am the HSA Accountholder 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)

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\_\_\_\_\_ New Email Address:

\_\_\_\_\_ New Home Address:

Online:

[www.vitaflex.net](http://www.vitaflex.net)

Fax:

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

E-mail:

[help@vitamail.com](mailto:help@vitamail.com)

Mail:

Vita Flex  
900 North Shoreline Blvd.  
Mountain View, CA 94043