

Employer Contribution Refund Form



Mail or fax completed forms to:

Address: HealthEquity, Attn: Client Services
15 W Scenic Pointe Dr, Ste 400, Draper, UT 84020

Fax: 520.844.7090

The employer contribution refund form is used to authorize a contribution refund to a contributing employer if a contribution was sent in error by that employer.

Employer Information	
Company Name	
Contact Name	Phone ()

Primary Account Holder Information			
Last Name	First Name	M.I.	
Street Address	City	State	ZIP
E-Mail Address (required)	Daytime Phone ()	SSN or 6-Digit HealthEquity ID Number	

Refund Information	
Amount to be refunded: \$ _____ Is the amount to be refunded an employer contribution, employee contribution, or both? _____ Please indicate type and amount below. Tax year: _____ <input type="checkbox"/> Employer amount \$ _____ <input type="checkbox"/> Employee amount \$ _____	Reason for Refund (required) <input type="checkbox"/> 1. Employee has not completed identity verification Per IRS Notice 2008 59, allowable reasons are: <input type="checkbox"/> 2. Employee never eligible (return of contributions for an employee that was once eligible, but no longer is, are not allowed). <input type="checkbox"/> 3. Employer contributed amount in error that exceeds the maximum annual contribution allowed in §223(b). Per HealthEquity HSA Custodial Agreement Section 12.01 <input type="checkbox"/> 4. Deposit keying error (i.e. \$1000.00 vs. \$100.00)

Banking Information	
How would the funds returned? Check one option. (Note: If neither option is selected, a check will be mailed.)	
<input type="checkbox"/> Option 1—Check <input type="checkbox"/> Option 2—Send to my verified EFT account Financial Institution: _____ Routing number: _____ Account number: _____	

Employer Authorization	
I attest that the reason for the contribution refund request is as indicated above. I understand that a \$20.00 processing fee applies and will be deducted from the amount returned to the employer. I also understand that it is an employer's responsibility to adjust the information reported to the employee on their W2 in Box 12, Code W.	
Employer Signature (required)	Date

Employee Authorization	
I authorize the refund of monies from my HealthEquity Health Savings Account as specified above. I understand the contribution will be reversed from my account and returned to my employer.	
Employee Signature (required for reasons for refund 2-4)	Date