



Instructions: Use this form to return funds to your HSA account. Please return completed form and corresponding check to Avidia Health, PO Box 370, Hudson, MA 01749. Questions on this form? Please call 855-248-6311 or send an email to HSAinfo@avidiahealth.com.

Account Holder Information: All fields required unless otherwise indicated

Form with fields for First Name, MI, Last Name, Street Address, City, State, Zip Code, Account #, and Social Security #.

Distribution Information:

Form with fields for Distribution Reversal Amount, Original Distribution Occurred In (Current Year or Prior Year), and tax year (TC 204 or TC 205).

Please indicate the reason you are requesting to reverse a distribution:

Form with two radio button options: 'A claim/distribution was overpaid...' and 'A distribution was withdrawn in error...'.

Note: Distribution reversals must be deposited to your account by the tax-filing deadline for the year in which the original distribution occurred (typically April 15 of the following year), NOT including extensions. If no year is specified, your distribution reversal will be deposited for the year in which it was received.

Signatures:

By my signature below I swear or affirm that this deposit, in the amount stated above, to my Health Savings Account is repayment of a mistaken distribution or distributions as defined by the Internal Revenue Service (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 _____ Date _____