Distribution of Excess HSA Contribution Form

motivhealth®

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**
Email Address:	**Phone:**	**Last 4 of SSN or MotivHealth ID number (6 or 7 digits):**	

Excess Contribution Information

Excess contribution amount: _____ **Tax year:** _____

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.

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contributed in excess of your contribution limit is subject to a penalty tax unless the excess and interest earned are withdrawn prior to the due date, including any extensions, for filing your federal income tax return.

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.

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.)**

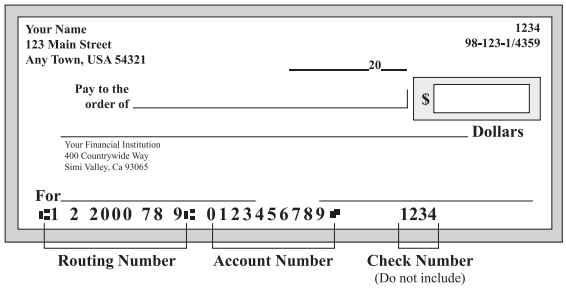
☐ **Option 2—One-time electronic funds transfer (EFT) Financial**

Institution: _____

Routing Number: _____

Account Number: _____

(Form must be accompanied by a copy of a voided or an actual check.)



☐ **Option 3—(Default)** Please allow approximately 3 weeks to receive your check.

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.