H.S.A. DISTRIBUTION REVERSAL FORM

Instructions Please mail this completed form with a check for the amount of the distribution to be reversed to: BCU 340 N. Milwaukee Ave Vernon Hills, IL 60061

Accountholder Information

First Name _____ **MI** ___ **Last Name** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Account Number _____ **OR** **Social Security #** _____

Distribution Information

Distribution Reversal Amount **Year Original Distribution Occurred**

$_____._____ _____

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

☐ **A claim/distribution was overpaid and I authorize redepositing the overpayment.**

☐ **A distribution was withdrawn in error and I authorize redepositing the amount.**

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**