Benefit Strategies, LLC (HSA Administrator)
CORRECT CONTRIBUITON ERROR HSA DISTRIBUTION REQUEST FORM

Instructions

1. Use this form only to distribute funds in order to correct contributions(s) made to your HSA in error.
2. **For death distributions, complete the Death Distribution Request Form.**
3. **For all other distributions, use the HSA Distribution Request Form.**
4. Fax the completed form to **603-647-4668** or mail to Benefit Strategies, LLC (HSA Administrator), PO Box 1300, Manchester, NH 03105
5. If you have any questions regarding distributions from your HSA, please call **888-401-3539 or email info@benstrat.com.**

Accountholder Information

Last Name | First Name | Middle Initial

Social Security Number | Employee ID and Employer (if applicable)

I direct HSA Administrator to make a distribution from my HSA for the following reason (choose only **one** reason per form):

Contribution Error – Employer and Accountholder Signatures Required	Amount To Distribute	Distribute Funds To
☐ Contributions continued to be sent by employer after I ceased to be HSA eligible	$	☐ Me ☐ Employer
☐ Contributions continued to be sent by employer after I terminated employment	$	☐ Me ☐ Employer
☐ Duplicate contribution made by employer	$	☐ Me ☐ Employer
☐ Incorrect amount withheld and contributed from payroll by employer	$	☐ Me ☐ Employer

Employer Signature Required For Above (Accountholder also signs below)

Signature of Employer | **Printed Name** | **Date**

Contribution Error - Accountholder Signature Only Required	**Amount To Distribute**	**Distribute Funds To**
☐ Contribution by employer alone exceeds my individual maximum contribution	$	☐ Me ☐ Employer
☐ Contributions were made but I was never HSA eligible	$	☐ Me ☐ Employer

Signature

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.

Signature of HSA Accountholder | Date