HealthSavings ADMINISTRATORS
Investing in a Healthy Future

Health Savings Account (HSA) Contribution Correction Form

Instructions: Complete this form to remove contributions made in error by you or your employer.

If you are completing this as a paper form, mail or fax your completed form to:

***HealthSavings* Administrators**
10800 Midlothian Tpke, Ste 240 • Richmond, VA 23235
Fax: 804.726.1570

Accountholder Information

First Name _____ Last Name _____ M.I. _____

Street Address _____ Apt / Suite _____

City _____ State _____ ZIP Code _____

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

Employer Information

Company Name _____

Contact Name _____ Phone Number _____

Street Address _____ Apt / Suite _____

City _____ State _____ ZIP Code _____

Reason for Correction

(All prior year contributions must be corrected by April 15th.)

- ☐ Duplicate contribution
- ☐ Employer withheld incorrect amount from payroll
- ☐ Employer continued to send contributions after employment ended
- ☐ Employer continued to send contributions after I switched health insurance plans

Date of Contribution(s) (mm/dd/yyyy)	Contribution Amount	Amount to Return
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____

Rev. 06/2017

Signature

By signing below, I authorize FPS Trust to reverse the above dollar amount(s) from my health savings account to correct the contribution error and return the funds to my employer. I understand that corrections to my investment funds, if applicable, will be sold on the date this form is processed and may be subject to a gain or loss. I understand that by completing this form, the contribution(s) will be reversed from my account if the account has a sufficient balance, and that they will not be included on tax reports if the error occurred this year, However, if the balance of the account is not enough to cover the request, only the available amount will be processed. If the error occurred last year, I understand that I will receive corrected tax forms and that I should consult with a tax advisor.

_____ _____

Accountholder Signature Date *(mm/dd/yyyy)*

FOR OFFICE USE ONLY

Sales Director _____

Partner Code _____

Case Number _____

10800 Midlothian Tpke, Ste 240 Richmond, VA 23235 (p) 888.354.0697 (f) 804.726.1570 HealthSavings.com