INVESTEDHEALTH
HEALTH SAVINGS ACCOUNTS

WITHDRAWAL FORM[1]

HSA ACCOUNT NO: _____

First Name:	MI:	Last Name:	SSN:
Street Address:		Phone No:	DOB
City	State:	Zip:	

☐ Withdrawal Request — Standard Disbursement I am requesting an Account Withdrawal in the amount of $_____. By signing at the bottom of page 2, I understand that InvestedHealth will report this distribution to the IRS as a normal distribution.

☐ Divorce Disbursement - I am requesting a transfer in the amount of $ to my former spouse pursuant to a divorce decree (a copy of the divorce decree is required). I understand that my ex-spouse must have established a InvestedHealth HSA for transfer to occur.

☐ Withdrawal Request — Excess Contribution Refund (InvestedHealth Code 6364) I am requesting to withdraw funds due to contributions made to my account that placed me in excess contribution status. By signing at the bottom of page 2, I understand that InvestedHealth will report this distribution to the IRS as an excess contribution. Funds contributed in excess of your contribution limit are subject to penalty and tax unless the excess and earnings are withdrawn by you prior to your tax filing due date, including any extensions, for filing your Federal Income Tax return. You should consult a qualified tax advisor in connection with your excess contribution removal. Excess Contribution Amount $ Tax year: 20 Note: The IRS requires InvestedHealth to report withdrawals that are considered refunds of excess contributions. In order for the withdrawal to be accurately reported, you may not withdraw the excess directly. Instead, you must request an excess contributions refund by faxing or mailing this signed and completed form to InvestedHealth, using the address or fax nInvestedHealther listed below.

☐ Withdrawal Request — For non payroll Contribution/Deposit Correction I am requesting an Account Withdrawal in the amount of $ for correcting a contribution error. Tax year of Correction: 20 Note: If your contribution is over the maximum IRS limit, please complete the Excess Contribution Refund Request section above. I certify that the above contribution was the result of a mistake of fact. I understand InvestedHealth is not required to accept the mistaken contribution and, that I am responsible for any tax consequences that may result from this transaction. Funds will need to pass through applicable clearing periods before they are returned. Requests may only be made during the current tax year and will result in a decrease in the total amount contributed for the applicable tax year. (All prior year contributions must be corrected by tax filing deadline, generally April 15 of the following year.) By signing bottom of page 2, I understand that mistaken contribution requests may only be accepted for contributions that were submitted by the Account Holder on a non payroll post-tax basis, and not for pre-tax contributions or those submitted from another entity. I affirm that the correction from my HSA in the amount stated above is a correction of a mistaken contribution resulting from a mistake of fact due to reasonable cause. I understand that I am solely responsible for any tax consequences and penalties resulting from improperly reporting this as a mistaken contribution, instead of a distribution of excess contribution, from my HSA.

☐ I further understand that it is my sole responsibility to determine the tax consequences of such distribution, to properly report the distribution on my federal income tax return and on Form 8889 for HSA or Form 8853 for MSA accounts, as well as on any state income tax returns, and to pay any taxes and penalties arising as a result of this distribution (see IRS Publication 969, Health Savings Accounts and other Tax-Favored Health Plans). A check reimbursement fee may apply and will be deducted from the account prior to making the distribution. See your terms and conditions for applicable fees. These fees could change at any time without notice. Please allow 30 business days processing time from the day InvestedHealth receives your completed form.

Account Owner's Signature: _____ Date: _____

[1] Please note: A processing fee may apply and will be deducted from your health savings account (HSA). Please refer to the Terms and Conditions which govern your HSA for the amount of such fee. There must be sufficient funds in your account to cover the processing fee.

Email form to
www.investedhealthhsa.com
877.516.0106