UMB Healthcare Services

Health Savings Account (HSA)

Authorization to Reverse Employer Contribution

UMB Health Savings Account Number (17-digit number found on your HSA statement)

7	2	5	7	5	2	7										

PLEASE READ: Page 1 (Sections A-D) must be completed by ***both*** the employer and the employee/HSA owner from whose account the HSA contribution is being reversed. Due to the confidential nature of the information pertaining to other HSA accountholders in section E, ***only*** **the employer** should access and complete Page 2 (Sections E-F.).

Sections A-D: To be completed by employee/account owner

Section A: Employer Information

Employer Name		
Address		
City	State	ZIP
Representative Name	Title	
Business Phone: (and extension)	Employer ID	
Email		

Section B: Employee/Account Owner Information

Employee/Account Owner First Name	MI	Last Name
Social Security Number (required)		

Section C: HSA Contribution to be Reversed

Original Deposit Date: (mm/dd/yyyy)
Amount to be DEBITED from the Health Savings Account identified at top of page 1:
Note: There must be sufficient funds in this account in order for UMB to process this request
Additional Comments:

Section D: Signature of Employee/Account Owner

By signing at the bottom of page 1, 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 or reported to the IRS as a distribution if the error occurred this year. (All prior year contributions must be corrected by April 15 of the following year.)

Signature of Employee/Account Owner _____ **Date** (mm/dd/yyyy) _____

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REMINDER! Due to the confidential nature of the information pertaining to other HSA accountholders in section E, only the employer should access and complete Sections E-F.

Sections E-F: To be completed by Employer

Section E: Method of Reversal (choose one)

Reverse the HSA contribution referenced in Section C using the method chosen below.

Note: There must be sufficient funds available in the HSA identified in Section B in order for UMB to complete this request. A representative will contact the employer's representative specified in Section A of this form if UMB has any questions about the request.

Funds will be returned to the employer

I would like my distribution to be in the following form (Please select one box below):

☐ **Check**
Note: Check will be made payable to the employer and mailed to the employer's contact at the address identified in Section A.

☐ **Direct Deposit**
If this is selection please provide employer information

Bank account number: _____

Routing Number: _____

Section F: Signature of Employer's Authorized Representative *Required

As indicated above, I ask UMB Bank to reverse our employer contribution to an employee's HSA. I understand and take complete responsibility and assume any and all liability for this reversal.

Signature of Employer's Authorized Representative **X**	**Date** (mm/dd/yyyy)
Print Name	Title

Return completed form to: **UMB Bank**
PO Box 161238
Altamonte Springs, FL 32716

E-mail: **hsasupport@myumbhsa.com**
Fax: **844-560-6761**