AvidiaBank

# Distribution Reversal Form

Instructions: Use this form to return funds to your HSA account. Please return completed form and corresponding check to Avidia Health, PO Box 370, Hudson, MA 01749. Questions about this form? Please call 210-659-8100.

## Account Holder Information: All fields required unless otherwise indicated

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| First Name | | MI | | Last Name | | | |
| Street Address | | City | | State | | Zip Code | |
| Account # | | **OR** | Social Security # | | - - | | |

## Distribution Information:

| | | | |
|---|---|---|---|
| Distribution Reversal Amount | $ | | |
| Original Distribution Occurred In: (*Current Year or Prior Year*) | ☐ Current Year (TC 204) | | (YYYY) |
| | ☐ Prior Year (TC 205) | | (YYYY) |

**Please indicate the reason you are requesting to reverse a distribution:**

☐ A claim/distribution was overpaid and I authorize Avidia Bank to redeposit the overpayment.

☐ A distribution was withdrawn in error and I authorize Avidia Bank to redeposit the amount.

**Note:** *Distribution reversals must be deposited to your account by the tax-filing deadline for the year in which the original distribution occurred (typically April 15 of the following year), NOT including extensions. If no year is specified, your distribution reversal will be deposited for the year in which it was received.*

## 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 the 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 _____

Rev. 07/2021



AvidiaBank