



HEALTH SAVINGS ACCOUNT CONTRIBUTION FORM

Use this form to make a normal contribution, mistaken distribution, or rollover contribution to your HSA. Use the HSA Transfer Form to request a transfer from another custodian/trustee into your HSA administered by Surency.

Accountholder Information

Last Name

First Name

Middle Initial

Social Security Number

Employer and Employee ID

Telephone Number

Email Address

Street Address

City

State

ZIP

Contribution/Recurring Information

Contributions over the cash minimum qualify to be invested and will be placed by default into an interest-bearing account. If you would like to change your investment allocation, you may do so by logging in to your account at Surency.com/AxcetHR. Future contributions will be allocated according to your investment allocation instructions.

Contribution Amount: \$ _____

Contribution for Tax Year: _____

Contribution Type (choose one below)

- Normal Contribution - A normal contribution would include a regular, catch-up, or post-tax contribution
- Mistaken Distribution - Contributions for a mistaken distribution must occur before December 31 of the year in which the mistaken distribution occurred. Contributions received after December 31 will be applied to the contribution maximum for the following year.
- Rollover from (choose one): HSA MSA (**Please include a check**)

Rules and Conditions Regarding Rollovers: A rollover is a way to move money or property from one HSA or Medical Savings Account (MSA) to another HSA. The Internal Revenue Code limits the number of rollovers that may be taken, how quickly rollovers must be completed and how the trustee or custodian must report the transaction.

Timeliness: The funds you receive from the distributing HSA or MSA must be deposited into another HSA within 60 days of receipt of funds.

Twelve Month Restriction: You can only make one rollover contribution per HSA per twelve-month period.

- I have enclosed a check from **the previous trustee or custodian for my rollover.**

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 and have met the requirements for making this transaction. I assume full responsibility for this transaction and will not hold Surency or Healthcare Bank liable for any adverse consequences that may result. I have not received tax or legal advice from Surency 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 by Surency and Healthcare Bank. If I have chosen rollover as the contribution type, I make an irrevocable election to treat this transaction as such.

Signature of HSA Accountholder

Date

****Enclose a check made payable to Surency****

Return completed form back to Surency at email: flex@surency.com - fax: 316-272-4841
or mail: P.O. Box 789773, Wichita, KS 67278-9773
866-818-8805 | Surency.com