

# HSA Contribution Form

Mail or fax completed forms to:

**Address:** HealthEquity, Attn: Member Services  
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020

**Fax:** 801.727.1005

## Primary Account Holder Information

Employer Name			
Last Name	First Name		M.I.
Street Address	City	State	ZIP
E-Mail Address (required)	Daytime Phone ( )	SSN or HealthEquity ID Number	

## Contributions

**Contribution tax year:** \_\_\_\_\_ Contributions for the prior tax year are accepted until Tax Day of the following year. Funds will be applied to the tax year of the date on the attached check if no year is indicated.

## Banking Information

What method would you like to use to make contributions to your HSA?

**Option 1—Check**

Include a check payable to HealthEquity with this form and mail to:

HealthEquity, Attn: Client Services, 15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020

Include the **tax year** and your **HealthEquity ID number** (6 or 7 digits) on the check.

When you provide a check as payment, you authorize HealthEquity to either use the information from your check to make a one-time, Back Office Conversion (BOC), electronic fund transfer from your account if eligible, or to process the payment as a check transaction. Funds processed via BOC may be withdrawn from your account as soon as the same day your payment is received.

**Option 2—One-time electronic funds transfer (EFT)**

**Fax this form and a copy of a voided check to:**

HealthEquity, Attn: Member Services, 801.727.1005.

Account type:  Checking  Savings Amount of deposit: \$ \_\_\_\_\_

Financial institution: \_\_\_\_\_

City/state: \_\_\_\_\_

Routing number: \_\_\_\_\_ Account number: \_\_\_\_\_

**Voided check is required if your personal account is not on file.**

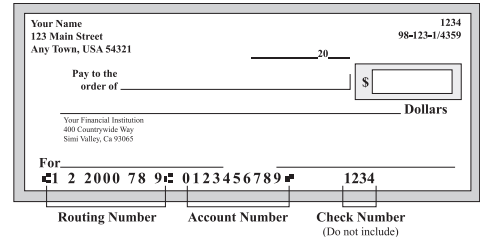
**Option 3—Recurring monthly electronic funds transfer (EFT)**

**Fax this form and a copy of a voided check to HealthEquity, Attn: Member Services, 801.727.1005. Voided check is required if your personal account is not on file.**

Amount of deposit: \$ \_\_\_\_\_ Day of month funds should be pulled: \_\_\_\_\_

Financial institution: \_\_\_\_\_ City/state: \_\_\_\_\_

Account type:  Checking  Savings Routing number: \_\_\_\_\_ Account number: \_\_\_\_\_



## Authorization

By signing below, I authorize the deposit of the above stated amount into my HealthEquity health savings account (HSA). I understand the eligibility requirements of the type of HSA deposit I am making and state that I qualify to make the deposit.

I assume complete responsibility for:

1. Determining that I am eligible for an HSA each year I make a contribution.
2. Ensuring that all contributions I make are within the limits set forth by tax laws.
3. The tax consequences of any contribution (including rollover contributions) and distributions.

Name (please print)	Signature	Date
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Please allow three to five business days after your form is processed by HealthEquity for your deposit to post to your account.