



Health Savings Account (HSA)

Authorization to Reverse Employer Contribution

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

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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		Date (mm/dd/yyyy)
X		
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**