

ADDITIONAL CONTRIBUTION FORM



Use this form to make an additional contribution to your HSA. For help with any questions, please call 1-877-924-3967 and ask for a BNY Mellon Health Savings Account representative.

ACCOUNT OWNER INFORMATION

Name: _____

Street Address: _____ City, State, Zip: _____

SSN: _____ Home Phone: _____ Bus. Phone: _____

Health Savings Account Number: _____

CONTRIBUTION INFORMATION

Amount: \$ _____

Your contribution will be deposited according to your current asset allocation.

Type of Contribution (Check one):

HSA regular EMPLOYEE contribution (including spousal) for tax year: _____

HSA regular EMPLOYER contribution (including spousal) for tax year: _____

If the tax year is not indicated, the contribution will default to the current year.

RETURN OF MISTAKEN DISTRIBUTION

Amount: \$ _____

Your returned mistaken distribution will be deposited into the liquid portion of your HSA account.

Return of Current Year Mistaken Distribution

Return of Prior Year Mistaken Distribution. If you mistakenly take a distribution for an expense that you thought was "eligible", but which you later learn is not, you can repay the amount into your HSA as long as the mistake of fact was due to a "reasonable cause", and the mistake is corrected no later than April 15 following the year you knew or should have known of the mistake. Check this box to make sure we report your contribution appropriately.

I certify that the above distribution was the result of a mistake and I authorize the Custodian/Trustee to redeposit the distribution as a mistaken distribution. I understand the Custodian/Trustee is not required to accept the mistaken distribution and I am responsible for any tax consequence that may result from the distribution.

SIGNATURE

I authorize and direct the Custodian to place this contribution in my HSA. I acknowledge that I am solely responsible for determining my eligibility to make HSA contributions and that I will not make annual contributions in excess of maximum allowable amount. If this is a rollover contribution, I certify that this deposit is being made within 60 days of my receipt of the HSA distribution that I am depositing and that this amount is eligible to be rolled over. I understand that contributions to my HSA will be reported to the Internal Revenue Service.

HSA Account Owner's Signature

Date

Mailing Instructions: Please make check payable to **PFPC Trust Company FBO Health Savings Account** and mail as noted below.

First Class Mail

WageWorks
P.O. Box 9813
Providence, RI 02940-8013

Overnight Mail

WageWorks
101 Sabin Street
Pawtucket, RI 02860-2348