HSA Reimbursement Form

HealthEquity®

Mail or fax completed forms to:

Address: **HealthEquity, Attn: Member Services**
PO Box 14374, Lexington, KY 40512

Fax: 801.727.1005

Primary Account Holder Information

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

Reimbursement Information

Provider Name	Date of expense
Patient Name	Total Reimbursement*

Type of expense: ☐ Medical ☐ Prescription ☐ Dental ☐ Vision (**Note**: No documentation is needed. Keep receipts for your records.)

*If the requested reimbursement amount is higher than your available balance, we will only process the reimbursement up to the available balance in the account. **An account closure fee is held in reserve from your account and may not be used for reimbursement.**

Reimbursement Method

☐ **Option 1—Check**
This method is slower. Please allow 7–10 business days to receive your check. **A $2.00 fee will be deducted from your health savings account (HSA).**

☐ **Option 2—Use the verified electronic funds transfer (EFT) account already tied to my HealthEquity® HSA.** (If an EFT is not on file, a check will be sent and a $2.00 fee may apply. Please allow 7-10 business days for the check to arrive.)

☐ **Option 3—Transfer the funds to the following account.**
(**Note**: E-mail address is required for EFT.)

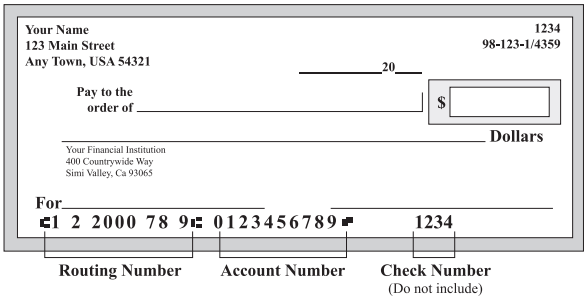
Account type: ☐ Checking ☐ Savings

Financial institution:_____

City/state:_____

Routing number:_____

Account number:_____



Form must be accompanied by a copy of a voided or actual check.

Reimbursement Authorization

By signing below, I authorize HealthEquity to reimburse me from my health savings account (HSA) for my expense in the manner specified above and I represent that the information I provided in this request is true and complete.

Name (please print)	Signature	Date

Reimbursement requests can also be made online at www.healthequity.com.