NueSynergy

Avidia Bank

Health Savings Account

Distribution Reversal Form

Instructions: Please mail this completed form with a check for the amount of the distribution to be reversed to: Avidia Bank, P.O. Box 370, Hudson, MA 01749.
For assistance, call (855) 472-9399 or send an email to: HSA@avidiabank.com.

Accountholder Information:

First Name | MI | Last Name

Street Address

City | State | Zip Code

Account # OR Social Security # - -

Distribution Information

Distribution Reversal Amount

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Original distribution occurred in:

☐ Current Year (YYYY)

OR

☐ Prior Year (YYYY)

NOTE: Distribution reversals must be deposited to your account by the tax-filing deadline for the year in which the original distribution occurred (typically April 15 of the following year), NOT including extensions. If no year is specified, your distribution reversal will be deposited for the year in which it was received.

Please indicate the reason you are requesting to reverse a distribution.

☐ A claim/distribution was overpaid and I authorize Avidia Bank to redeposit the overpayment.

☐ A distribution was withdrawn in error and I authorize Avidia Bank to redeposit the amount.

Signatures

By my signature below I swear or affirm that this deposit, in the amount stated above, to my Health Savings Account is repayment of a mistaken distribution or distributions as defined by the Internal Revenue Service (resulting from a mistake of fact due to reasonable cause). I understand that I am solely responsible for any tax consequences and penalties of improper reporting of this deposit as repayment of a mistaken distribution, instead of a contribution, to my HSA.

Name Date