

HSA Reimbursement 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

HealthEquity[®]
Building Health Savings[™]

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 (6 or 7 digits) | |

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: _____

Your Name
123 Main Street
Any Town, USA 54321

1234
98-123-1/4359

_____ 20 _____

Pay to the order of _____ \$ _____ Dollars

Your Financial Institution
400 Countrywide Way
Simi Valley, Ca 93065

For _____

⑆ 1 2 2000 78 9 ⑆ 0123456789 ⑆ 1234

Routing Number Account Number Check Number
(Do not include)

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.