MyHSA EXCESS CONTRIBUTION CORRECTION

(PLEASE PRINT)

Instructions – This form is used to request the removal of funds contributed in excess of your contribution limit.

ACCOUNT HOLDER INFORMATION		
Name: (First):	**(MI):**	**(Last):**
Social Security Number:	**Daytime Phone Number:**	
Mailing Address:		
City:	**State:**	**Zip:**
Email Address:		

Please read and complete the following:

Funds contributed in excess of your contribution limit are subject to penalties and taxes unless the excess and earnings on the excess contribution are withdrawn by you prior to the due date, including any extensions for filing your Federal Income Tax return. We recommend that you consult with a qualified tax advisor regarding any excess contribution removal.

Note: The Internal Revenue Service requires Alliance Benefit Group of IL to report withdrawals that are considered refunds of excess contributions. In order for the withdrawal to be accurately reported, you may not withdraw the excess funds directly. Instead, you must request an excess contribution correction by faxing or mailing this signed and completed form to Alliance Benefit Group of IL using the address or fax number listed below.

A $20 excess contribution correction fee will be deducted from your account.

Amount of the Excess Contribution $ _____ for Tax Year _____

HSA ACCOUNT HOLDER AUTHORIZATION AND SIGNATURE:

I hereby request and authorize Alliance Benefit Group of Illinois to process the above requested excess contribution distribution from my Health Savings Account. I understand that the funds requested will be delivered to me utilizing standard services provided by the U.S. Postal Service unless I have previously completed the Authorization for Direct Deposit (EFT) Form. I further certify that I understand the requested HSA distribution will be processed as soon as possible following availability of funds and that there may be additional fees (see fee schedule) charged by Alliance Benefit Group of Illinois associated with this distribution. I understand that I am responsible for any consequences resulting from this distribution including taxes and penalties owed. I agree to indemnify and hold Alliance Benefit Group of Illinois and The Charles Schwab Trust Company harmless from any resulting liabilities. I acknowledge that neither Alliance Benefit Group of Illinois nor The Charles Schwab Trust Company have provided me with legal advice and I further agree to consult with my personal tax consultant or legal counsel as I deem appropriate for guidance.

HSA Account Client Signature: _____ Date: _____

Please complete and return this form to:
Alliance Benefit Group
Attn: MyHSA Department
456 Fulton Street, Suite 345
Peoria, IL 61602
Or fax the completed form to 800-688-4329.

If you have any questions please call customer service at 800-57 MyHSA (1-800-576-9472)