

HSA Withdrawal Form



COVENTRY CONSUMER CHOICESM



Instructions:

1. Complete Account Holder Information section (please print).
2. Complete Health Savings Account Withdrawal Request and/or Request for Excess contribution withdrawal sections as appropriate. Services must be incurred before you can be reimbursed for Health Savings Account Expenses.
3. **Sign and Date the form in the Account Holder Authorization section (if submitted without account holder signature, claim(s) will be denied).**
4. Please make copies for your records, as these documents will not be returned.
5. If you have any questions regarding your account or claims, please call the customer service number or visit the member website address located on your MHBP Consumer Option ID card.
6. Paper checks will not be distributed until accumulated reimbursement amounts exceed \$25.
7. Electronic fund transfers (i.e., direct deposit) will be deposited directly into the designated bank account regardless of the reimbursement amount.

Account Holder Information – Must be completed (Please Print)

Account Holder Name (Last, First, MI) _____ Member ID Number _____ M5010
 Group Number _____

Address (MUST be physical street address, will not accept PO Box) _____ City _____ State _____ ZIP Code _____ () _____
 Daytime Phone Number _____

Health Savings Account Withdrawal Request

Distribution from a Health Savings Account not used for the purpose of paying qualified medical expenses is subject to IRS penalties and income tax. Please consult a tax advisor before any such reimbursement/withdrawal.

Patient's Name and/or Expense	Date of Service/Transaction		Amount of Expense to be Reimbursed
	From	To	
1.			\$
2.			\$
3.			\$
4.			\$
5.			\$
Total reimbursement requested from your Health Savings Account			\$

Note: If you have an HSA-Compatible FSA or HRA you will need to complete a separate FSA/HRA Reimbursement Form for those eligible expense(s).

Request For Excess Contribution Withdrawal

Excess contributions include any amount deposited into your Health Savings Account by either you or the Plan that exceeds the maximum amount that you can contribute to your HSA annually as limited by the IRS. Request for excess contribution withdrawals must be received prior to the deadline for filing the account owner's federal income tax return (usually April 15th) to avoid an excise tax penalty. For 2009, the annual IRS limits are \$3,000 for Self-Only and \$5,950 for Self and Family coverage.

Excess Contribution Tax Year (e.g. 2008, 2009)	Amount
	\$
Total reimbursement requested from your Health Savings Account	\$

Account Holder Authorization

I hereby certify that:

- The information given on this reimbursement form is complete and correct.
- I have not received reimbursement for these expenses from the reimbursement account or from any other source.
- I understand that amounts reimbursed may not be claimed as deductions on my or my spouse's income tax return.
- I understand that it is my responsibility to determine the impact of this disbursement from my Health Savings Account on my income taxes.
- I have received and read the printed material regarding the Health Savings Account and understand all of the provisions.

This authorizes my insurance company, employer, hospital, physician, or pharmacy (or any other agents) to release or receive all information with respect to myself or any of my dependents for use in connection with the administration of this plan or any other plan providing benefits or services to me, to any of my dependents, or for related health benefits services.

X _____ / _____ / _____
 Account Holder Signature (If submitted without signature, claim(s) will be denied) Date

Mail your completed form to: Coventry Consumer Choice, PO Box 7757, London, KY 40742 or fax to (606) 330-1377