



##37PNC#####

Reversal of Employer/Administrator HSA Contribution Form

Only an employer or administrator should complete this form to request the correction of a contribution made by the employer or administrator in error. All prior year contribution reversal requests must be corrected by April 15.



Fax completed form to:
855.588.1028



Mail completed form to:
WealthCare Saver
P.O. Box 162177
Altamonte Springs, FL 32716

Section 1: Administrator / Employer Information

_____ ADMINISTRATOR NAME		_____ EMPLOYER NAME	
_____ CONTACT NAME		_____ CONTACT EMAIL	_____ TELEPHONE NUMBER
_____ STREET ADDRESS			
_____ CITY	_____ STATE	_____ ZIP CODE	

Section 2: Account Holder Information

_____ LAST NAME		_____ FIRST NAME		_____ MIDDLE INITIAL	
_____ ACCOUNT NUMBER (12 digits beginning with 601)				_____ SOCIAL SECURITY NUMBER	
_____ STREET ADDRESS					
_____ CITY	_____ STATE	_____ ZIP CODE			

