Health Savings Account Disbursement Form

EMPLOYER:			
NAME:	Last First MI	SS#:	
ADDRESS:	Street City State ZIP	PHONE :	( )
EMAIL:			

☐ Please check if your name or address has changed.

QUALIFIED MEDICAL EXPENSE CLAIMS				
Date(s) of Service MM/DD/YY	Provider Name	Patient Name	Description of Service	Claim Amount
				$
				$
				$
				$
				$
			Totals:	$

NON-QUALIFIED, ELECTIVE DISTRIBUTIONS		
Date(s) of Service MM/DD/YY	Amount	Type of Distribution Request: N = Non-qualified medical expense E = Excess contribution reduction
	$	
	$	
	$	
	$	

EMPLOYEE'S CERTIFICATION FOR DISBURSEMENT

For expenses that I have requested be reimbursed as Qualified Medical Expenses above, I certify that I have actually incurred these eligible expenses. I understand that expense incurred means hat service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed or are not reimbursable from any other source. I understand that any amounts reimbursed may not be claimed as deductions on my or my spouse's income tax returns. I understand that it is my responsibility to determine the impact of this disbursement on my income taxes. I have received and read the printed material regarding the Health Savings Account and understand all the provisions. I understand there is no charge for EFT (Direct Deposit) disbursements and check disbursements are $3.00.

Employee Signature: ______________________________ DATE: ________ /_______/________

Submit By:

Mail

997 Governors Lane
Suite 175
Lexington, KY 40513

Online	Email	Fax
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