Allegiance℠ by Cigna Healthcare

HSA MISTAKEN PAYROLL OR EMPLOYER CONTRIBUTION CORRECTION REQUEST FORM

Instructions

1. Use this form to communicate with your employer that you have mistaken payroll or employer contribution amounts that need to be corrected and reimbursed through payroll.
2. **Send the completed form to your Employer, they will forward to their Allegiance Reimbursement Account Specialist to process**
3. If you have any questions regarding the contribution amounts made to your HSA, please call 1-877-424-3570.

Accountholder Information

Last Name _____ First Name _____ Middle Initial _____

Social Security Number _____ Employer Name _____

I direct my Employer to request that Allegiance Benefit Plan Management Inc. (TPA),make a distribution from my HSA for the following reason:

Mistaken Payroll or Employer Contribution Removal

☐ **Mistaken Payroll or Employer Contribution Removal**

Tax Year_____ Corrections for mistaken contributions must occur before December 31 of the year in which the mistaken contribution occurred.

Date mistaken contribution started_____ and ended_____

(Enter the date the mistaken contribution was posted into the account. If multiple mistaken contributions were made, enter the date of the first mistaken contribution.)

Mistaken Payroll Contribution Amount Total $_____

Mistaken Employer Dollar Contribution Amount Total $_____

Reason for mistaken contribution_____

Signature

I certify that I am the HSA Accountholder or an individual authorized to execute this transaction. I have read and understand the instructions and any rules or conditions relating to this transaction. I assume full responsibility for this transaction and will not hold Allegiance Benefit Plan Management Inc. liable for any adverse consequences that may result. I have not received tax or legal advice from Allegiance Benefit Plan Management Inc. and, if necessary, will seek the advice of a tax or legal professional to ensure my compliance with related laws. All information provided by me is true and correct and may be relied upon Allegiance Benefit Plan Management Inc.

Signature of HSA Accountholder _____ Date _____

Employer signature _____ Date _____

This form must be signed by both the HSA Accountholder and the Employer and must be sent to Allegiance Benefit Plan Management Inc. Attn Reimbursement Account Specialist (TPA) PO Box 4346 Missoula MT, 59806. Or faxed to 1-877-424-3539 for processing.

NOTE: the removal of the mistaken contribution may take up to 5 days to complete by Allegiance