HEALTH SAVINGS ACCOUNT
QUALIFIED MEDICAL EXPENSE REIMBURSEMENT FORM

Please do not attach any receipts to this request. Please retain all receipts with your tax records. If the IRS audits your HSA, they will require proof that you used your HSA funds to pay for qualified medical expenses.

Instructions: Complete the information below for reimbursement of qualified medical expenses incurred by you, your spouse or other eligible dependents. Be sure to provide all requested information on this form. If this form is incomplete, we may not be able to process your request and it will be returned to you for completion. Once a completed form is received your request will be processed.

Completed forms can be submitted to Associated Bank via: secure email to healthsavingsaccounts@associatedbank.com; mail to Associated Bank, NA Attn: HSA Department MS 7009, PO Box 19097, Green Bay, WI 54307-9097; or fax to (920) 405-2324. If you have any questions on the completion of this form, please contact our HSA Customer Care Department at (800) 992-2651.

Account Owner Information

Name:_____ Social Security Number (last 4 only): XXX-XX-_____

Mailing Address*: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____

*Check requests related to this reimbursement will be sent to the current address on file. If you would like to update your address please contact our Customer Care Department at (800) 992-2651 or visit a branch location.

Reimbursement Information

HSA Number (required): _____ Reimbursement Amount**: _____

**If the requested amount is greater than the balance in your account, your reimbursement will be equal to the balance in your account.

Method of Reimbursement: Direct Deposit*** ☐ Check Mailed ☐

***Checking this box will authorize us to use the financial information provided below for the requested reimbursement.

Direct Deposit Account Information (complete only if Direct Deposit is selected above, otherwise leave blank)

Name of Financial Institution receiving funds: _____

Location of Financial Institution (City and State): _____

Routing Number: _____ Account Number: _____ Account Type: Checking ☐ Savings ☐

Signature

I certify that I am the proper party to receive payment(s) from this HSA and that all information provided by me is true and accurate. I further certify that no tax advice has been given to me by the Custodian. All decisions regarding this withdrawal are on my own. I expressly assume the responsibility for any adverse consequences which may arise from this withdrawal and I agree that the Custodian shall in no way be held responsible. If requesting direct deposit, I hereby authorize Associated Bank, N.A. to initiate credit entries to my account indicated above and the financial institution named above to credit the same to such account. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. If the direct deposit transmission fails, I acknowledge that a check will be mailed to me at the address on file for my HSA.

Signature _____ Date _____