HSA Contribution Form

HSAs Done Right!

Mail or fax completed forms to:

Address: **American Health Value**
PO Box 8063, Boise, ID 83707-2063

Fax: 208.331.2651

Primary Account Holder Information

Employer Name			
Last Name	First Name		M.I.
Street Address	City	State	ZIP
E-Mail Address (required)	Daytime Phone ( )	SSN	

Contributions

Contribution tax year:________________________

Contributions for the prior tax year are accepted until April 15 of the following year. Funds will be applied to the tax year of the date on the attached check if no year is indicated.

Banking Information

What method would you like to use to make contributions to your HSA?

☐ **Option 1—Check**

Include a check payable to American Health Value with this form and mail to:

American Health Value, Attn: Client Services, PO Box 8063, Boise, ID 83707-2063

Include the **tax year** and your **American Health Value ID number** (6 or 7 digits) on the check.

When you provide a check as payment, you authorize American Health Value to either use the information from your check to make a one-time, Back Office Conversion (BOC), electronic fund transfer from your account if eligible, or to process the payment as a check transaction. Funds processed via BOC may be withdrawn from your account as soon as the same day your payment is received.

☐ **Option 2**—One-time electronic funds transfer (EFT)

Fax this form and a copy of a voided check to:
American Health Value, Attn: Member Services, 208.331.2651.

Account type: ☐ Checking ☐ Savings Amount of deposit: $____________________

Financial institution:____

City/state:____

Routing number:____________________ Account number:____________________

Your Name
123 Main Street
Any Town, USA 54321
1234
98-123-1/4359
________20___
Pay to the order of ________________ $
________________ Dollars
Your Financial Institution
400 Countrywide Way
Simi Valley, Ca 93065
For________________
⑆1 2 2000 78 9⑆ 0123456789⑈ 1234
Routing Number Account Number Check Number (Do not include)

Voided check is required if your personal account is not on file.

☐ **Option 3—Recurring monthly electronic funds transfer (EFT)**

Fax this form and a copy of a voided check to American Health Value, Attn: Member Services, 208.331.2651. Voided check is required if your personal account is not on file.

Amount of deposit: $________________________ Day of month funds should be pulled:____________________

Financial institution:________________________ City/state:________________________

Account type: ☐ Checking ☐ Savings Routing number:____________________ Account number:____________________

Authorization

By signing below, I authorize the deposit of the above stated amount into my American Health Value health savings account (HSA). I understand the eligibility requirements of the type of HSA deposit I am making and state that I qualify to make the deposit.

I assume complete responsibility for:

1. Determining that I am eligible for an HSA each year I make a contribution.
2. Ensuring that all contributions I make are within the limits set forth by tax laws.
3. The tax consequences of any contribution (including rollover contributions) and distributions.

Name (please print)	Signature	Date

Please allow three to five business days after your form is processed by American Health Value for your deposit to post to your account.