American Health Value
HSAs Done Right!

Deposit Form

OFFICE USE ONLY

ID: _____ Chk #: _____ Amt: _____ Year: _____

Account Holder Name: _____

Account #: _____

Amount of Deposit: $_____

Apply to Calendar Year: _____
*Deposits received between January 1 and April 15 can be applied to **either** the current year or the previous year – all other deposits are applied to the current year only.*

Employer: _____
(If your employer provides the HSA Qualified Insurance)

Check the appropriate item to designate type of deposit:

- ☐ **Contribution**
- ☐ **Rollover:** Rollover must be done within 60 days of receipt of funds. If you are not sending the original rollover check, please provide documentation of when it was received (copy of check or other paperwork received with the check that provides a date and shows the dollar amount).
- ☐ **Refund from provider**
- ☐ **Return funds withdrawn in error**
- ☐ **Other (explain):** _____

Mail Completed Form To:

American Health Value
P.O. Box 8063
Boise, ID 83707