Send, email or fax to:
Wayne County Benefits Administration
500 Griswold St - 14th Floor, Detroit
Fax: 313-967-1228
eMail: benefits@waynecounty.com

*Please do not return the forms to the address listed in the top left-hand corner*
# Employer Contribution Refund Form

Mail or fax completed forms to:
**Address:** HealthEquity, Attn: Client Services  
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020  
**Fax:** 520.844.7090

The employer contribution refund form is used to authorize a contribution refund to a contributing employer if a contribution was sent in error.

## Employer Information

<table>
<thead>
<tr>
<th>Company Name*</th>
<th>Contact Name*</th>
<th>Phone*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wayne County</td>
<td>Livia Calderoni</td>
<td>313-224-1329</td>
</tr>
</tbody>
</table>

## Primary Account Holder Information

<table>
<thead>
<tr>
<th>Last Name*</th>
<th>First Name*</th>
<th>M.I.*</th>
<th>Street Address*</th>
<th>City*</th>
<th>State*</th>
<th>ZIP*</th>
<th>E-Mail Address (required)</th>
<th>Daytime Phone*</th>
<th>Last 4 of SSN or HealthEquity ID Number (6 or 7 digits)*</th>
</tr>
</thead>
</table>

## Refund Information

- **Amount to be refunded:** __________  
  Please indicate type and amount below. Tax year: 2017  
  - [ ] Employer amount __________  
  - [ ] Employee amount __________  
  Note: EE and ER amounts must match the total amount to be refunded indicated above

## Reason for Refund:

- [ ] 1. Employee has not passed identity verification/CIP (No employee signature required)  
  Per IRS Notice 2008-59, allowable reasons are:  
  - [ ] 2. Employee never eligible (return of contributions for an employee that was once eligible, but no longer is, are not allowed).  
  - [ ] 3. Employer contributed amount that exceeds the maximum annual contribution allowed in §223(b).  
  - [ ] 4. Administrative deposit error (i.e., $1,000.00 vs. $100.00)

## Banking Information

- How would you like the funds returned? Check one option. (Note: If no option is selected, a check will be mailed)  
  - [ ] Option 1 – Credit Invoice (credit may be used for future employer payments. If not used within 60 days, funds will be returned via check)  
  - [ ] Option 2 – Check  
  - [ ] Option 3 – Send to verified Employer EFT account on file. Please provide last 4 of account number __________ (required).  
  - [ ] Option 4 – One-time electronic funds transfer (EFT). (Form must be accompanied by a copy of a voided or an actual check)

## Employer Authorization

I attest that the reason for the contribution refund request as indicated above. I understand that a $20.00 processing fee applies and will be deducted from the amount returned to the employer. I also understand that it is an employer’s responsibility to adjust the information reported to the employee on their W2 in Box 12, Code W.

<table>
<thead>
<tr>
<th>Employer Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

## Employee Authorization

I authorize the refund of monies from my HealthEquity Health Savings Account as specified above. I understand the contribution will be reversed from my account and returned to my employer.

<table>
<thead>
<tr>
<th>Employee Signature (required for reasons for refund 2-4)</th>
<th>Date</th>
</tr>
</thead>
</table>

Note: Incomplete forms will not be processed. In such cases, we will attempt to contact you via email or phone to advise that the form was missing information.

www.healthequity.com

866.382.3510

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