



**American Fidelity Health
Services Administration**

A member of the American Fidelity Group

Toll Free: 1-866-326-3600
Phone: (405) 523-5699
Fax: (405) 523-5072
Website: www.athsa.com

**HEALTH SAVINGS ACCOUNT
Contribution Form**

Make check payable to: InvesTrust, N.A. Mail check and completed form to: American Fidelity Health Services Administration, PO Box 25523, Oklahoma City, OK 73125.

A. Accountholder Information

Name	Social Security #
Address	DOB (mm/dd/yyyy)
City, State, Zip	Daytime Phone
Employer Name*	Home Phone

*If the HSA was established separate from your employer, the employer name does not need to be completed.

B. Contribution Information

Date of contribution	_____ (mm/dd/yyyy)	Contribution amount	\$ _____	Contribution for tax year	20__
Source of contribution	<input type="checkbox"/> Individual <input type="checkbox"/> Employer	Contribution Type	<input type="checkbox"/> Normal <input type="checkbox"/> Catch-up contribution (ages 55 and over) <input type="checkbox"/> Redeposit of mistaken distribution		

C. Additional Information or Special Instructions

I certify that this is an eligible HSA contribution 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. I expressly assume the responsibility for any adverse consequences which may arise from this contribution and I agree that the Custodian shall in no way be held responsible. I understand that it is my responsibility to contact my tax advisor or legal counsel when appropriate. Furthermore, I understand that I am responsible for all tax consequences associated with this contribution.

Signature of Accountholder

Date

FOR OFFICE USE ONLY	RECEIVED BY:	PROCESSED ON:	PROCESSED BY:
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