Return of Reimbursement Account Overpayment

HealthEquity®
Building Health Savings℠

Email, mail or fax completed forms to:

Email: memberservices@healthequity.com

Address: **HealthEquity, Attn: Member Services**
15 W Scenic Pointe Dr, Ste 100, Draper, UT 84020

Fax: 520.844.7090 (cover sheet not required)

Primary Account Holder Information

Employer Name (if applicable) Standard Motor Products, Inc.			
Last Name	First Name		M.I.
Street Address	City	State	ZIP
Email Address (required)	Daytime Phone ( )	Last 4 of SSN or HealthEquity ID Number (6 or 7 digits)	

Return of Overpayment Information

Account to Apply Overpayment to: ☐ FSA/LPFSA ☐ HRA ☐ DCRA ☐ HIA

Card Transaction Date	**Claim Number**
Provider/Merchant	Amount $
Card Transaction Date	**Claim Number**
Provider/Merchant	Amount $

Banking Information (If no option is selected, form is void)

☐ **Option 1—**Check

Include a check payable to HealthEquity with this form and mail to:
HealthEquity, Attn: Client Services, 15 W Scenic Point Dr, Ste 100, Draper, UT 84020

Please include "overpayment" in the memo line of your check and include which card transaction or claim number to reference payment.

When you provide a check as payment, you authorize HealthEquity 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 Funds processed via BOC may be withdrawn from your account as soon as the same day your payment is received.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)

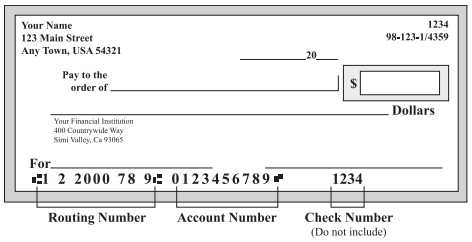
Fax this form and a copy of a voided check to:
HealthEquity, attn: Client Services, 520.844.7090.

Account type: ☐ Checking ☐ Savings Amount: $_____

Financial institution:_____

Routing number:_____ Account number:_____

Form must be accompanied by a copy of a voided or an actual check.



☐ **Option 3—**Use the verified EFT account already tied to my account.

Authorization

This form is required to correct an overpayment made for your reimbursement account. By signing below, I swear or affirm that the correction from my reimbursement account in the amount stated above is a correction of an overpayment resulting from a mistake of fact due to reasonable cause.

Name (please print)	Signature	Date