

HUNTINGTON HEALTH SAVINGS ACCOUNT REIMBURSEMENT REQUEST

Please complete this request form in full. The following terms apply to reimbursements from your account:

1. A reimbursement can only be made from funds that are currently in your account.
2. Reimbursements will only be made at the request of the HSA account holder and must be payable to the same.
3. You do not need to supply evidence that this request is for an expense that meets IRS 213d requirements in order to receive reimbursement. You should keep copies of receipts, Explanation of Benefits or other supporting documentation. To meet 213d guidelines, reimbursements must be for expenses incurred after your Health Savings Account is established.
4. Reimbursements will occur only on the second and last Fridays of the month in which Huntington National Bank ("Bank") is open for business (the "Reimbursement Dates"). If the Bank is closed on a Reimbursement Date, reimbursement will be made on the next business day in which the Bank is open for business.
5. The Reimbursement Request must be received by close of business on or before the Wednesday which immediately precedes a Reimbursement Date; provided however, that if the Bank is not open on the Wednesday which immediately precedes a Reimbursement Date, the Reimbursement Request must be received by the immediately preceding Tuesday.
6. Reimbursements will be made by check.
7. **If your account is invested in more than one (1) Huntington mutual fund, the Bank will first attempt to fill this request from your Money Market Mutual Fund, if available. Thereafter, if necessary, approximately equal amounts will be drawn from each of your remaining mutual funds. If your balance in the Money Market Mutual Fund is insufficient to meet this Reimbursement Request, and if the balance in an individual mutual fund is insufficient to complete its pro-rata share of this Reimbursement Request, the Bank shall complete the remainder of this request by drawing from your mutual fund that has the largest balance.**

Account Holder Information:

Name: _____ SSN# _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____

This request is for the following eligible medical expenses: _____

Requested Amount:

I have read and understand the terms listed above and request reimbursement from my health savings account in the amount of _____ dollars and _____ cents.

Account Holder's Signature: _____ Date _____ Telephone# (____) _____

Please return this form to:

**Huntington HSA Administration
c/o CBA Benefit Services
73 East Wilson Bridge Road Suite B-6
Worthington, Ohio 43085
Phone: 866-880-0068
Fax: 614-880-0092**