MidAmerica
Administrative & Retirement Solutions, Inc.
P.O. Box 24927 Lakeland, FL 33802
855.329.0095 ♦ Fax 863.577.4460♦ www.midamerica.biz

Health Reimbursement Arrangement (HRA)

Account Reimbursement Claim Form

►**Please attach your documentation to this page.**

Section 1 This section must be completed fully for all claims.

Please print

Employer Name:_____

Employee Name:_____ Social Security #:_____

Address:_____

City, State Zip:_____ Daytime Phone Number: (_____)_____

Date of Birth:_____ Are you actively employed? ☐ Yes ☐ No If no, provide termination date:_____

☐ Check here if this is a permanent address change. Email Address:_____

Section 2 This section must be completed for all claims incurred by you, your spouse, or other eligible dependants. **Supporting documentation MUST be attached**.

EXPENSES:

If you are currently participating in your Employer's Health Savings Account (HSA), please note that you can only be reimbursed for dental, vision, preventative care expenses, and premiums from your HRA.

Approved HRA claims are processed within 7 – 10 business days.

List expenses in the table below and attach a statement or itemized invoice from the individual or entity to which payment for medical expenses was made showing the nature of the service rendered, and to or for whom rendered. **Cancelled checks or undocumented receipts are not acceptable documentation per IRS regulations. Balance due statements will only be accepted if they include the above listed information.** Reimbursable expenses must total at least $100 before being submitted for reimbursement.

Date of Expense	Name of Service Provider	Name of Covered Participant / Dependant	Service Provided	Amount Requested for Reimbursement / Payment

Applicable distribution fees will be deducted from the total eligible claim amount (per IRS Guidelines). **Total HRA Claim: $**_____

Section 3 Death Claim

If this distribution is on behalf of a deceased Participant, you must provide a copy of the death certificate. Please provide the name and the address of where the check should be mailed.

_____

_____

_____

Section 4 Employee Signature is **required** to process this claim.

I request payment from the reimbursement account for the expenses listed above. To the best of my knowledge, my statements on this form are true and complete. I certify that all expenses for which reimbursement or payment is claimed were incurred either by me or by my eligible dependant(s). I certify that the medical expenses in this claim are eligible for reimbursement and are "qualifying expenses" as defined by the Internal Revenue Code Section 213(d). I understand that if these medical expenses are not qualified medical expenses I may be liable for the payment of all related taxes on amounts received pursuant to this claim. I certify that the medical expenses claimed are not covered by insurance and have not been reimbursed or cannot be reimbursed under any other health plan coverage. I certify that I have not previously submitted this claim for reimbursement and that this is not a duplicate claim. I take full responsibility for the accuracy of all information I have provided. I further understand that reimbursed expenses cannot be claimed as a credit on my personal income tax return.

☐ After this claim has been processed, check this box if you elect to permanently opt out of participation in and waive any future reimbursements from the Health Reimbursement Arrangement. If you elect this opt out, you will forfeit your entire remaining account balance, including any vested funds. You may, however, continue to submit claims for reimbursement of expenses that you incurred prior to the opt-out date, but you must submit these expenses for reimbursement within 90 days after the end of the plan year.

Employee Signature:_____ **Date:**_____

We want to promptly process your claim. Please complete all appropriate sections as the claim form will be returned to you if incomplete. Please keep a copy of this claim form for your records. Submit Completed Form and attachments to:

MidAmerica Administrative & Retirement Solutions, Inc.
Dept: HRA Admin
P.O. Box 24927 Lakeland, FL 33802

Office Use Only

Balance_____ **Account**_____ **Effective Date**_____

Fees_____ **Notes**_____ **Direct Deposit**_____

HOW TO FILE YOUR CLAIM

Section 1

Complete ***ALL*** personal information on the reverse side of this form.

Section 2

Indicate the amount of each healthcare claim being submitted. This account reimburses you for services **incurred** for healthcare purposes. The type of service rendered determines claim eligibility. Not all healthcare expenses are reimbursable. *(See IRS Section 213(d) for guidelines).*

If you are currently participating in your Employer's Health Savings Account (HSA), please note that you can only be reimbursed for dental, vision, and preventative care expenses from your HRA.

HEALTH CARE EXPENSES – must be incurred by you, your spouse, or other eligible dependants prior to reimbursement.

Attach to this claim form one of the following:

- The Explanation of Benefits (EOB) statement returned to you from the insurance carrier indicating the amount for which you are responsible. Please be advised that any medical, dental, or vision expense covered by insurance in part or in full must first be submitted to your insurance carrier.
- Co-pay receipts if you are covered under a managed care or prescription drug plan
- When there is no insurance for healthcare expenses, submit an itemized bill with the following information:
  - Name of provider and patient
  - Service cost, date, and description
  - Notation when there is no insurance coverage

Total your expenses and enter the amount on the front of this form. **Cancelled checks or undocumented receipts are not acceptable documentation per IRS regulations. Balance due statements will only be accepted if they include the original date of service, description of services provided, and the cost of the services rendered.**

Insurance premiums must also be incurred prior to reimbursement (i.e.; March premium can be reimbursed no earlier than February).

If your claim is being made payable to a third party (Insurance Provider or Employer) your claim will not be subject to a distribution fee. However, if the claim is being paid to you, your claim may be subject to a distribution fee. For more information specific to your Employer's HRA plan, please refer to your Plan Highlights.

Section 3

If this distribution is on behalf of a deceased Participant, you must provide a copy of the death certificate. Once we have received a copy of the death certificate, MidAmerica will keep it on file for future reference for future claims. Therefore, MidAmerica only requires that a copy of the death certificate be sent once.

Section 4

SIGN the claim form. This is required on all submissions; otherwise the claim will not be processed.

This Health Reimbursement Arrangement Account is regulated by the Internal Revenue Service. Our documentation guidelines are provided to help you determine what qualifies as a reimbursable expense and to assist us in the adjudication process. It is the responsibility of each participant to comply with these guidelines and to avoid submitting duplicate or ineligible claims. Failure to comply with the above guidelines will delay the payment of your claim.

This outline is intended for quick reference. For more specific guidelines, please call MidAmerica Administrative & Retirement Solutions, Inc. at **1-855-329-0095** as our Customer Service Department will be happy to answer your questions.

MidAmerica
Administrative & Retirement Solutions, Inc.
P.O. Box 24927 Lakeland, FL 33802
855.329.0095 ♦ Fax 863.577.4460 ♦ www.midamerica.biz