# Health Reimbursement Arrangement (HRA)
# Flexible Spending Account (FSA)
# Claim Form

MidAmerica Administrative & Retirement Solutions

**Please attach documentation to this page. Return completed form to:**
**MidAmerica Administrative & Retirement Solutions**
**Attn: HRA Admin, P.O. Box 24927 Lakeland, FL, 33802 ♦ 855.329.0095 ♦ Fax 863.577.4460**
**www.midamerica.biz**

## 1 YOUR INFORMATION

**Please Print. This section must be fully completed for all claims.**

Employer / Plan Sponsor Name:_____

Employee / Participant Name: _____ Last four digits of Social Security #: _____

Address: _____ City, State, Zip: _____

Daytime Phone Number: (_____)_____ Date of Birth: _____ Personal Email Address: _____

☐ Check here if this is a permanent address change. Are you actively employed with this employer? ☐ Yes ☐ No If no, provide separation date:_____

## 2 CLAIM INFORMATION

**Expenses:**

**Approved claims are processed within 7-10 business days. Please review the documentation instructions on page 3. Be sure to attach acceptable documentation as outlined in the instructions. Failure to provide the requested information or acceptable documentation may delay your request.** Reimbursable expenses must total at least $100 before being submitted for reimbursement. Applicable distribution fees will be deducted from the total eligible claim amount (per IRS guidelines).

**1. Medical Expense Claims – Complete the following table for any medical expenses incurred by the participant, spouse or eligible dependent. Please select if the expense should be reimbursed from your FSA or HRA.**

| HRA | FSA | Date of Expense | Name of Service Provider | Name of Covered Participant, Spouse, or Eligible Dependent | Service Provided | Reimbursement Amount |
|---|---|---|---|---|---|---|
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☐ I certify that my spouse and/or eligible dependents are enrolled in employer-sponsored group coverage*

**Total HRA Medical Claim: $_____**
**Total FSA Medical Claim: $_____**

☐ If the amount of my submitted FSA medical expenses exceed the available balance of my FSA, please pay any unreimbursed amount from my HRA account.

**FSA Daycare / Dependent Care Provider and Dependent Information (please complete if any of the above expenses were daycare or dependent care):**

Dependent's Name: _____ Age:_____

Dependent's Name: _____ Age:_____

If bills or receipts are not available, your service provider must complete the following:

Provider's Signature: _____ Provider's Tax ID: _____ Date:_____

**2. HRA Premium Expense Claims – Complete the following table for any premium expenses incurred by the participant, spouse, or eligible dependent. Please indicate if the expense is recurring.**

| Date of Expense | Name of Insurance Premium Provider | Name of Covered Participant, Spouse, or Eligible Dependent | Type of Insurance Premium** | Reimbursement Amount | Recurring (check here) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

☐ Cancel recurring claim request (select if you wish to stop your current recurring claim)

**Total HRA Premium Claim: $_____**

**Total HRA Recurring Premium Claim: $_____**

*If additional space is needed, please attach a separate page to include all requested information in the table.*

**Only applies to Integrated HRA plans. An Integrated HRA is an HRA that you have access to, and your employer contributes to, during active employment.*

*** Medical, dental, vision, long-term care, Medicare B, C, D, Medicare supplemental plan*

## 2 CLAIM INFORMATION

**For HRA Recurring Premium Expense Claims Only (fill out only if you specified that any of the claims in Section 2.2 are recurring):**

To whom do you want the reimbursement paid? (check one): ☐ Pay to me ☐ Pay to my insurance provider ☐ Pay to my employer

If you chose to have the payment made to someone other than yourself, please provide the name and address of where the check should be mailed:

Name: _____ Address: _____

☐ I certify that my recurring premium expense(s) remains in effect and reimbursable for a 12-month period. I understand after 12 months, I will be required to renew my recurring claim by submitting a new form and providing updated policy documentation for approval. I understand that if at any time during the 12 months my premium amount changes or the policy terminates, I must notify MidAmerica immediately.

## 3 REIMBURSEMENT METHOD

How would you like to receive your reimbursement? ☐ Check in the mail ☐ New Direct Deposit ☐ Direct Deposit (already on file with MidAmerica)

If you selected Direct Deposit for the first time, please provide your banking information below. Your HRA/FSA distributions may be deposited directly into your account or joint account with your spouse at your bank or other financial institution.

**Bank Account Information**

Bank Name: _____ Bank Address: _____

Bank Telephone Number: _____ Account Type: (check one) ☐ Checking ☐ Savings

Transit Routing Number

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

Account Number

| | | | | | | | | | | | | | | | | | |
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Type of Transaction (check one): ☐ New request for Direct Deposit ☐ Change current Direct Deposit information ☐ Cancel Direct Deposit

## 4 DEATH CLAIM

If this distribution is on behalf of a deceased participant, you must provide a copy of the death certificate. A death claim is when a spouse, eligible dependent or beneficiary submits a claim against a deceased participant account. This may be for their own eligible medical expenses or any final expenses incurred by the participant. Please provide the name and the address of where the check should be mailed.

Name:_____ Address: _____

## 5 YOUR SIGNATURE

**Employee signature is required to process this claim.**

I request payment from the reimbursement account for the expenses listed above in Section 2. 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, my spouse or my eligible dependent(s). I understand that a medical expense is considered incurred when medical care is provided to me or my eligible dependent(s), not when I am formally billed, charged or have paid for the medical care. Therefore, I understand that insurance premiums must be incurred prior to reimbursement, and I cannot be reimbursed for an entire year of premiums in advance. 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.

If I provided direct deposit information in Section 3 of this claim form, I authorize MidAmerica Administrative & Retirement Solutions to deposit my HRA and/or FSA claims directly into my account until I give further written notice to MidAmerica. I understand that it may take up to 72 hours from the time MidAmerica processes my payment for the funds to post to my designated bank account. Also, I grant MidAmerica the right to correct any electronic funds transfer resulting from an erroneous overpayment by debiting my account to the extent of such overpayment.

As part of the Affordable Care Act, the DOL has mandated that employees be permitted to either irrevocably suspend their HRA for a fixed period of time, or permanently opt-out of the HRA by forfeiting their account balance and waiving any future contributions. Electing either option would preserve the eligibility of an individual to claim a Code § 36B premium tax credit, otherwise known as a Premium Subsidy for Healthcare Exchange coverage, should they otherwise qualify.

Should you choose to suspend your HRA, you, your spouse and any qualifying dependents will cease to have access to the HRA during the suspension and will be ineligible to incur any new expenses for reimbursement during the suspension. For your account to be reactivated, MidAmerica must receive a written notice requesting the account be unsuspended. Please be advised that the account becomes available at the start of the plan year following the request to unsuspend. To learn more about the Code § 36B premium tax credit, please visit: http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/The-Premium-Tax-Credit.

☐ Check this box to temporarily suspend access to your HRA in order to receive the premium tax credit if you qualify. You will not be able to submit or incur expenses for reimbursement during the time your HRA is suspended; however, your employer is still able to contribute to your account during the suspension and your account will continue to earn interest.

☐ Check this box if you elect to permanently opt-out of the HRA, forfeit your account balance and waive any future contributions after this claim has been processed. Participants with nominal account balances may choose this option if they wish to forfeit their remaining balance.

_____ _____

Employee Signature Date

# How to File Your Claim

## SECTION 1

Complete ALL personal information in this section.

## SECTION 2

### Health Care Expenses

Expenses must be incurred by you, your spouse or other eligible dependents.

Select the type of reimbursement account (FSA or HRA) the expense should be claimed from. Indicate the amount of each health care claim being submitted.

Not all employers offer both an FSA and HRA. If your employer offers both an FSA and HRA, both of which provide coverage for the same medical expenses, MidAmerica will process the reimbursement based on the ordering rules established in the plan. For example, if the plan identifies that the FSA "pay first," your expense will be applied to the FSA until the balance is depleted and then automatically reimburse from the HRA.

This account reimburses you for services **incurred** for health care purposes only. The type of service rendered determines claim eligibility. Not all health care expenses are reimbursable. *(See IRS Section 213(d) for guidelines).*

Examples of Common Health Care Expenses:

- Office Visit Co-pays
- Physician Service Co-pays
- Prescription Co-pays
- Insurance Plan Deductibles
- Insurance Plan Coinsurance

For a full listing of eligible medical expenses, please visit https://www.irs.gov/pub/irs-pdf/p502.pdf. Please note that not all HRA plan designs allow for full 213(d) reimbursement. To find what your HRA covers, reference your Plan Highlights. This can be found by logging into your account at www.midamerica.biz, or by contacting our Customer Service team at (855) 329-0095.

### Defining Eligibility

You, your spouse, and any qualifying dependents are able to seek reimbursement for eligible medical expenses and premiums from the HRA or FSA. Qualifying dependents include children under the age of 27 at the end of the tax year and any tax dependents.

### HSA / HRA Interaction

If during the HRA plan year, you or your employer, or your spouse or spouse's employer contributed to a Health Savings Account (HSA), your HRA must be suspended for the plan year. While suspended, you can only seek reimbursement for dental, vision, preventative care, and premium expenses from your HRA.

Please review and complete the Account Suspension Form if you or your spouse is contributing to an HSA. Notice to suspend is irrevocable during the plan year. A change to remove the suspension must be received prior to the start of the next plan year.

### HRA Premium Expenses

You may only seek reimbursement for premium expenses incurred by you, your spouse or other eligible dependents once you are no longer actively employed by the plan sponsor.

### HRA Recurring Premium Expenses

A recurring monthly expense is an expense that you incur monthly in the same amount each month. For example, a monthly health insurance premium may qualify as a recurring monthly expense.

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

At this time, MidAmerica only establishes recurring claims for monthly premium expenses. If the amount of your recurring expense changes, please notify us immediately by completing an updated claim form.

### FSA Daycare / Dependent Care Expenses

This form substantiates expenses you have incurred with the provider listed on this form. If you have incurred expenses for the care of a dependent to allow you and/or your spouse to work, please list the name(s) and ages(s) of person(s ) who have received day care / dependent care. Copies of bills and receipts must also be attached to support your request for reimbursement.

If those documents are not available, you must have the provider of service sign the appropriate space and indicate tax ID number on the front of this form.

## SECTION 3

Please select your preferred method of reimbursement. If you are signing up for Direct Deposit for the first time, or if you are changing your bank information, provide your account numbers, and attach the appropriate documentation. **Be sure to sign the authorization.**

## SECTION 4

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 5

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

## POSSIBLE HRA FEES

HRA distributions may be subject to a $5.00 distribution fee per paper claim (up to an annual maximum of six distribution fees per calendar year).

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.

## ONLINE CLAIMS SUBMISSION

You are able to submit your claims online at any time. Claims submitted online have a quicker turnaround time and reduced distribution fee of $2.50 per claim (up to an annual maximum of six distribution fees per calendar year.)

1. Go to www.midamerica.biz
2. Select "Submit Claims" from the blue header at the top of the page.
3. Simply follow the prompts on the screen until you receive a confirmation of successful submittal.

## DOCUMENTATION REQUIREMENTS

**Documentation must include the following:**

- Date of service
- Description of service
- Cost of service
- Individual receiving the service
- Provider of the service

**Notes on documentation:**

### Explanation of Benefits (EOB)

- Your plan may require an EOB for claim approval. Please refer to your Plan Highlights for details on the documentation required by your plan for reimbursement.
- An EOB is a statement returned to you from the insurance carrier indicating the amount for which you are responsible. Remember any medical, dental, or vision expense covered by insurance in part or in full must first be submitted to your insurance carrier.

### Long-Term Care Premium Policies

- Payments made for long-term care premiums are subject to annual maximums for the year in which payment is made. Therefore, proof of payment is required for all claim requests.

### Recurring Premium Reimbursements

- The first initial setup for reimbursement requires detailed documentation.
- The documentation must show:
  - Name/type of recurring claim to be reimbursed,
  - Amount of claim
  - Frequency of claim
  - For instance, a copy of the premium notice from your insurance carrier would be acceptable.

### When a Medical Necessity Form is Needed

- You may need to complete and have your doctor sign a Medical Necessity Form showing that the service is medically necessary. Common services that require this form include:
  - Counseling
  - Physical and Occupation Therapy
  - Massage Therapy
  - Acne Treatment
  - Adaptive Equipment.