HRA/FSA Consolidated Claim Form

Return this completed form to:
Mail: U.S. BENCOR/MidAmerica
Attn: PO Box 24927, Lakeland, FL 33802-4927
Fax: (863) 577-4460 | Phone: (855) 329-0095

STEP 1 Participant Information

Employer

Date of Birth (mm/dd/yyyy)

First Name | Last Name | M.I. | Social Security Number

Mailing Address | City | State | Zip | Telephone

Email Address

Check if permanent address change: ☐ Actively employed with employer? ☐ If no, separation date?

This form can also be used to request changes to your direct deposit information, even if not submitting a new claim. Please complete Steps 1, 3, and 5.

STEP 2 Claim Information

NOTE: Choose one or both options.

Approved claims are processed within 7–10 business days. Be sure to attach acceptable documentation as outlined in the instructions. Failure to provide the requested information or acceptable documentation may delay your request. Applicable distribution fees will be deducted from the total eligible claim amount (per IRS guidelines). For PSERS Retirees: If you are receiving PSERS monthly premium assistance, you must reduce your medical premium reimbursement request by this amount.

☐ Option 1 One-Time Expenses

NOTE: Choose one. ☐ HRA Only ☐ FSA Only ☐ FSA then HRA*

Complete the following table for any one-time eligible expenses incurred by the participant, spouse, or eligible dependent. Expenses may include (one-time) premiums, long-term care, prescriptions, medical, dental, or vision. For a complete list of eligible expenses, please visit IRS Publication 502: Medical and Dental Expenses.

Date of Expense	Name of Service Provider	Name of Covered Participant, Spouse, or Eligible Dependent	Service Provided	Payable to: (Self, Provider)	Amount to Reimburse
*FSA funds used until exhausted, followed by HRA funds.				**Total One-Time Claim Expenses:**	

☐ Option 2 Recurring HRA Premium Expenses (Payable to Self Only)

Complete the following table for any recurring HRA premium expenses incurred by the participant, spouse or eligible dependent. Expenses submitted here will be established as recurring automatic disbursements processed approximately 30 days prior to the payment due date. For example, you will receive payment for January's premium in early December. Recurring premium payments can be set up for a maximum of 12 months. After 12 months, you must resubmit your recurring premium request.

Policy Effective Date	Name of Insurance Provider	Name of Covered Participant, Spouse, or Eligible Dependent	Type of Insurance Premium	Group Insurance? (Yes/No)	Policy Expiration Date	Amount to Reimburse
					Total Recurring Premium Expenses:	

PLEASE INITIAL ALL BELOW: ***(Note:*** *Initials are required for processing. Please review claim instructions for additional information.)*

_____ I understand that I cannot simultaneously participate in a Health Reimbursement Arrangement (HRA) and receive an advance Premium Tax Credit (PTC). Any receipt of a PTC while receiving reimbursements from my HRA can result in adverse tax consequenses, per IRS regulations.

_____ I understand my recurring premium expense(s) remain in effect and reimbursable through the policy expiration date. I understand I am required to renew my recurring claim in advance of the policy expiration by submitting a new claim form and updated policy documentation for approval.

_____ I understand if at any time prior to the policy expiration date my premium amount changes, I begin to receive an advance Premium Tax Credit (PTC), or the policy terminates, I must notify MidAmerica to avoid potentially adverse tax consequences per IRS regulations.

STEP 3 Payment Options

NOTE: Choose options that apply from Step 2.

Please note one-time expenses from Step 2, Option 1 may be payable to self or your insurance or service provider. Recurring premiums are only payable to self.

Option 1 Self

How would you like to receive your reimbursement? Choose one:
If you selected "New Direct Deposit" OR "Update existing direct deposit with new account details below", please provide your new banking information below.

☐ Check in the mail ☐ New Direct Deposit ☐ Direct Deposit (already on file with MidAmerica)
☐ Update existing direct deposit with new account details ☐ Remove existing direct deposit and receive future reimbursements via check

DIRECT DEPOSIT INFORMATION:

Bank Name | Account Number | ABA Routing Number

Name on Account | Account Type (e.g., Checking, Savings)

Option 2 Insurance or Service Provider

Attach an additional sheet to supply information for multiple insurance or service providers.

Payee Name | Policy # / ID # / Account ID #

Address | City | State | Zip

STEP 4 Additional Information

NOTE: Choose any that apply.

☐ **FSA Day Care/Dependent Care Provider and Dependent Information:**
Complete if any of the above expenses were day care or dependent care expenses.

Dependent Name | Age

Dependent Name | Age

PROVIDER INFORMATION **Note: Required if bills/receipts are unavailable.**

▶ Provider Signature

Provider Tax ID | Signature Date (mm/dd/yyyy)

☐ **Death Claim:**
Upon the death of a participant, the participant's surviving spouse and/or eligible dependents may submit a death claim for reimbursement of eligible expenses for themselves or final medical expenses incurred by the participant until the vested account balance is exhausted. Distributions on behalf of a deceased participant require a photocopy of the death certificate. Please reference Plan Highlights for more information regarding beneficiaries. Please provide payment name and the address below.

Name on Account | Address

☐ **Cancellation of Recurring Premium:**
Indicate which previously submitted recurring premium you would like to cancel below, the reason for cancellation, and effective date of the cancellation.

Premium Type | Reason for Cancellation | Effective Date | Premium Type | Reason for Cancellation | Effective Date

STEP 5 Authorization

I request payment from the reimbursement account for the expenses listed above in Step 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 Step 3 of this claim form, I authorize MidAmerica 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 business 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.

▶ Participant Signature | Signature Date (mm/dd/yyyy)