HEALTH REIMBURSEMENT ARRANGEMENT (HRA)
Recurring 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: ______________ Date Last Employed: ______________ Email Address: ______________

☐ Check here if this is a permanent address change

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:

List your recurring expenses in the table below and attach a copy of receipts, bills or statements showing amounts and services. Documentation ***must*** list the amounts of service, effective dates/dates of service, and name of service provided.

Date of Expense / Effective Date of Expense	Name of Service Provider	Service Provided	Amount Requested for Reimbursement

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

* *To whom do you want the reimbursement paid? (Check one):* ☐ *pay to me,* ☐ *pay to my insurance provider, or* ☐ *pay to my Employer*
When do you want your monthly reimbursement to be issued (*check one*): ☐ the 15th of the month, or ☐ the last business day of the month
If you choose to have payment made to someone other than yourself, please provide the name and address of where the check should be mailed:

____

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____

Claims received by the 15th of the month will be paid on the last business day of the month. Claims received between the 16th and last business day of the month will be paid on the 15th of the next month (Example: Received January 17th payment will be made February 15th).

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.

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____

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.

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. Return to: MidAmerica Administrative & Retirement Solutions, Inc., Dept: HRA Admin., 211 E. Main St., Suite 100, Lakeland, FL 33801
Fax: (863) 688-4200 ◆ Phone: (863) 688-4500 ◆ Toll-Free: (800) 430-7999 ◆ www.midamerica.biz

Office Use Only

Balance ______________ **Account** ______________ **Effective Date** ______________

Fees ______________ **Notes** ______________ **Direct Deposit** ______________

HOW TO FILE A RECURRING 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 only. The type of service rendered determines claim eligibility. Not all healthcare expenses are reimbursable. *(See IRS Section 213(d) for guidelines).*

RECURRING MONTHLY EXPENSES: – must be incurred by you, your spouse, or other eligible dependants prior to reimbursement.

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.

The first initial set up for reimbursement requires detailed documentation. The documentation must show the name/type of recurring claim to be reimbursed, along with the amount and frequency of the claim. For instance, a copy of the premium notice from your insurance carrier would be acceptable. **For the initial set up of a recurring expense, cancelled checks or undocumented receipts are not acceptable documentation per IRS regulations. Cancelled checks [copy of front and back] are acceptable for subsequent months. 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.**

After initial set up of recurring distributions, you must supply MidAmerica with monthly documentation as proof of continuation of payment of the recurring claim. Acceptable documentation for subsequent months following the initial set-up can be supplied in the form of a cancelled check (copy of **front and back**), bank statement, a letter from the service provider on the company letterhead, or a premium notice with the effective date/date of service.

Recurring monthly distributions will be subject to a $5.00 distribution fee ($30.00 annual maximum).

Total your expenses and enter the amount on the front of this form.

Please note: If the amount of your recurring expense changes, please notify us immediately, so we can make adjustments to your payments accordingly.

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 requirements 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 **1-800-430-7999** as our Customer Service Department will be happy to answer your questions.

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