MidAmerica
Administrative & Retirement Solutions, Inc.
402 South Kentucky Ave., Suite 500, Lakeland, FL 33801
800.430.7999 ♦ Fax 863.688.4200 ♦ 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:_____ 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:**

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.

**Approved HRA claims are processed within 7 – 14 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 reimbursements.

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

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
402 S. Kentucky Avenue, Suite 500, Lakeland, FL 33801

**Office Use Only**

**Balance**_____ **Account**_____ **Effective Date**_____

**Fees**_____ **Notes**_____ **Direct Deposit**_____