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

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:_____ 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 dependents. **Supporting documentation MUST be attached.**

EXPENSES:

If you are currently participating in a Health Savings Account (HSA), please note that you can only be reimbursed for dental, vision, post-deductible, preventative care, and premium expenses from your HRA.

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

List your recurring 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 Insurance Provider	Name of Covered Participant / Dependent	Type of Premium	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*

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:

_____

_____

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 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 premiums for an entire year are not eligible for reimbursement until the care is given. 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.

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 and will be ineligible to incur any new expenses during the suspension. For your account to be reactivated, MidAmerica must receive a written notice requesting the account be unfrozen. Please be advised that the account becomes available at the start of the plan year following the request to unfreeze. 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 if you wish to suspend your HRA account and waive contributions to your account for a fixed period of time.

☐ 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.

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
Dept: HRA Admin
P.O. Box 24927 Lakeland, FL 33802

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. A medical expense is considered incurred when medical care is provided to you or your eligible dependent(s), not when you are formally billed, charged or have paid for the medical care. Therefore, premiums for an entire year are not eligible for reimbursement until the care is given. 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 a Health Savings Account (HSA), please note that you can only be reimbursed for dental, vision, post-deductible, preventative care and premium expenses from your HRA. To suspend your HRA so that you are able to participate in an HSA, please complete MidAmerica's HRA Account Suspension Form. This form is available by logging into your account at www.midamerica.biz, calling (855) 329-0095 or by emailing healthaccountservices@midamerica.biz.

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

You are able to set up a recurring claim for your monthly premium expenses. To set up your recurring claim, you would need to provide a Premium Notice, such as a bill or acceptance letter from the insurance company that includes the following:

- The premium amount
- The effective date of the coverage
- Name of the person who is insured – this will be you, your spouse or qualifying dependent

Each month after your recurring claim has been established, the IRS requires that MidAmerica receives some sort of documentation. You can send in one of the following items to satisfy this requirement:

- An "I Attest" statement confirming that your recurring claim is still in effect and reimbursable. MidAmerica has provided a simple Attestation Form, which can be found by logging in to your account on www.midamerica.biz. You may mail, fax or email the statement. If sending via email, email to claims@midamerica.biz
- Proof of payment (cancelled check showing that it was cashed [both sides of check], bank statement, etc.)
- Proof that the claims were incurred (letter from the insurance company showing the policy still in force, monthly statement, etc.)

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 services rendered.

Recurring monthly distributions may be subject to a $5.00 distribution fee ($30.00 annual maximum). For more information specific to your employer's HRA plan, please refer to your Plan Highlights.

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. Your recurring claim is valid for 12 months. After 12 months, a new Recurring Claim Form and Premium Notice must be submitted to renew your recurring claim.

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 at **1-855-329-0095** and our Customer Service Department will be happy to answer your questions.

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