HRA Consolidated Claim Form

Return completed form to:
Mail: MidAmerica Administrative & Retirement Solutions
Attn: HRA, P.O. Box 24927, Lakeland, FL 33802
Email: claims@MyMidAmerica.com | **Fax:** (863) 577.4460 | (855) 329-0095

1 Your Information Complete ALL personal information in this section

Name of Employer:	Social Security # (Last four-digits): ☐☐☐☐
Name of Participant:	Date of Birth:
Current Mailing Address:	Phone:
City, State, Zip:	Personal Email:

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

2 Medical Expense Eligibility and Claim Submission Information

You, your spouse, and any qualifying dependents may seek reimbursement for eligible medical expenses from your HRA. Qualifying dependents include taxable dependents and any children under the age of 27 at the end of the tax year.

This account may reimburse you for medically necessary expenses that have been rendered. IRS guidelines prevent reimbursement of non-health related expenses or for prepayment of services that have not been rendered. The type of service rendered determines claim eligibility as not all healthcare expenses are reimbursable.

Examples of Common Eligible Health Care Expenses:

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

Examples of Common Services that may require a **Medical Necessity Form:**
(Medical Necessity Forms must be signed by a healthcare provider and state a diagnosis)

- Counseling/Psychotherapy
- Occupation / Massage Therapy
- Acne or Other Dermatologic Treatments

For a full listing of eligible medical expenses, please visit **IRS Publication 502: Medical and Dental Expenses**. **Please note that not all HRA plans allow for full 213(d) reimbursement**. **You may confirm what your HRA plan allows by logging into your account at www.MyMidAmerica.com and referencing your Plan Highlights**. You may also contact Participant Services at (855) 329-0095 for additional assistance.

*Complete the following table for all **HRA medical expenses**. If additional space is needed, please attach a separate page that includes all information requested in this table.*

Date of Expense	Name of Service Provider	Name of Covered Individual	Service Provided	Reimbursement Amount

☐ I certify that my spouse and/or eligible dependents are enrolled in my employer's group sponsored coverage or another source of group sponsored coverage

* **Total HRA Medical Claim: $** ☐☐☐☐☐☐☐☐☐

* Reimbursable expenses must total at least $100 before being submitted. Any applicable distribution fees will be deducted from the total eligible claim amount (per IRS guidelines).

Documentation Requirements and Submission Instructions

All documentation must include the following 5 Keys of Verification:

- Date of service
- Description of service
- Cost of service
- Name of patient receiving the service
- Name of provider rendering the service

Examples of Acceptable Documentation:

- Explanation of Benefits (EOB) **–** Detailed statement from the health insurance company explaining what services were paid for on your behalf and lists any personal financial responsibility you may bear. (PREFERRED DOCUMENT)
- Itemized Statement – Statement from the provider that includes the 5 Keys of Verification and cannot include a balance forward.
- Itemized Receipts – Credit card and other payment receipts that include the 5 Keys of Verification
- Proof of Prescription – An itemized printout from the pharmacy or prescription receipt showing the Rx name or Rx number.

Failure to provide the requested information or acceptable documentation will result in processing delays and/or denial. Documentation is required for auditing purposes and to ensure compliance with IRS guidelines governing the use of tax-free HRA funding.

Submission Instructions:

Claims may be securely submitted online at your convenience. The following instructions are to Submit A One-Time Reimbursement Request:

- Go to www.MyMidAmerica.com:
- Click "Submit Claims" from the blue header at the top right
- Click "One-Time Reimbursement Request"
- Follow the on-screen prompts until you receive a confirmation number indicating a successful submittal

You may submit more than one expense by clicking the "Add Another Expense" button as pictured below. You may add up to 15 expenses in one claim. For multiple expenses, please upload one file that contains all supporting documentation and check box "Does this file contain receipts for multiple expenses"

3 Premium Expense Eligibility and Claim Submission Information

You, your spouse, and any qualifying dependents may seek reimbursement for eligible premium expenses from your HRA. Qualifying dependents include taxable dependents and any children under the age of 27 at the end of the tax year.

This account may reimburse you for past premium expenses or premium expenses that will become due within the next 30 days. This account may also reimburse you for premium expenses that reoccur monthly or annually, known as **recurring premiums**. Premium expenses may include medical, dental, vision, long-term care coverage, Medicare, Medicare Prescription and Medicare supplement policies. IRS guidelines prevent reimbursement of pre-tax premiums, indemnity policies, or prepayment of coverage prior to 30 days in advance.

Please follow the premium information below and the Documentation Requirements & Submission Instructions to ensure you are aware of the steps necessary to receive timely reimbursements.

Long-Term Care Premiums:

- Long-Term Care Premiums cannot be set up as a recurring claim. Claims for reimbursement must be submitted each month or any time following the month of coverage.
- Reimbursement of long-term care premiums are subject to annual limits based on the year in which the payment is made. Annual limits are determined by the IRS and, as a result, proof of payment is required for all claims.

Recurring Premiums:

- Premiums setup on a recurring basis may be paid to you, to your employer, or to your insurance provider. A designation must be made below.
- Attestation may be required dependent upon who the payment is made to or the type of premium being paid.
- Recurring payments WILL NOT be issued if attestation is not received for the applicable premiums.
- ALL recurring premiums must be resubmitted every 12-Months or when the policy renews, whichever occurs first.

Recurring Premium Attestation:

- IRS guidelines require monthly or annual confirmation that coverage remains in effect. This confirmation is referred to as attestation.
- Monthly Attestation is required if you are enrolled in an individual insurance policy and the reimbursement in made payable to you.
- Annual (12-Month) Attestation is available, along with monthly attestation, if you are enrolled in employer group health insurance and/or Medicare/Medicare Supplement.
- No Attestation is required if premium payments are made payable to your insurance provider, to your employer, or if your employer provides attestation on your behalf.

If you are enrolled in a combination of individual insurance policy and Medicare/Medicare Supplement, you may consider monthly attestation for all premiums to avoid duplicate processing fees). See page 3 for further details on fees.

*Complete the following table for all **HRA premium expenses.** Check the Recurring column box and indicate if the expense is monthly or annual to establish a recurring premium.*

Date of Expense	Name of Insurance Provider	Name of Covered Individual	Type of Insurance Premium	Reimbursement Amount	Recurring	Monthly or Annual
					☐	
					☐	
					☐	
					☐	
					☐	

☐ Cancel recurring premium request (select this option only if you wish to stop your current recurring claim) **Total HRA Premium Claim: $** | | | | | | | | |

Complete only if you indicated that any of your premium expenses are recurring in the table above.

Please select who should receive the recurring premium reimbursement.
If you choose to have the payment made to someone other than yourself, please provide the name and address of where the check should be mailed:

☐ Self ☐ Insurance Provider ☐ My Employer Name:_____ Address:_____

If selecting employer group health insurance or Medicare/Medicare Supplement AND a 12-Month attestation, please check the "I certify" box to initiate the 12-Month attestation:

☐ **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. Failure to alert MidAmerica of a change in policy could result in IRS penalties.**

Documentation Requirements and Submission Instructions

Initial Setup of your Monthly Recurring Claim:
To establish a Recurring Claim, follow these instructions:

- Complete the HRA Consolidated Claim Form
- Attach a premium notice from your insurance provider or a letter showing proof of premiums from your employer. These documents must include name of covered individual, name of provider, cost, and coverage period. **Payment coupons are not acceptable**

Attesting to your Monthly Recurring Claim:
To submit the Monthly Attestation Form by mail, follow these instructions:

- Go to www.MyMidAmerica.com;
- Select "Forms" from the blue header at the top-right
- Select "Health Reimbursement Arrangement";
- Select "HRA Attestation Form"

Initial Setup of your Monthly Recurring Claim Online:
To establish a Recurring Claim Online, follow these instructions:

- Go to www.MyMidAmerica.com;
- Select "Submit Claims" from the blue header at the top-right
- Select "Submit Monthly Premium Reimbursement Request
- Select "Yes" from the drop-down menu when asked if you would like to receive monthly attestation email reminders
- Follow the on-screen prompts until you receive a confirmation number indicating a successful submittal

Attesting to your Monthly Recurring WEB Claim:
To submit the Monthly Attestation Online, follow these instructions:

- Click the link contained with the monthly email that you will receive by the 1st of each month

4 HSA / HRA Interaction

☐ Check here if you or your spouse are actively contributing to an HSA

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 restricted for the plan year. While restricted, you can only seek reimbursement for dental, vision, preventative care, and premium expenses from your HRA.

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

5 HRA Processing 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. 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). For more information specific to your Employer's HRA plan, please refer to your Plan Highlights.

6 Reimbursement Method

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

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

Bank Name: _____ Bank Address: _____

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

Transit Routing Number

Account Number

7 Death Claim

Upon the death of a participant, the participant's surviving spouse, eligible dependents or beneficiaries are eligible to submit a death claim and reimbursed for their eligible medical expenses or final expenses incurred by the participant until the vested account balance is exhausted. If this distribution is on behalf of a deceased participant's account, the spouse, eligible dependents or beneficiaries must provide a copy of the death certificate. MidAmerica only requires that a photocopy of the death certificate for our records and future claims. Please reference the Plan Highlights to ensure the plan allows beneficiaries.

_____ _____

Beneficiary Signature (Only if this is a death claim) Date

8 Authorization

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, my spouse 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 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.

_____ _____

Participant Signature (Required) **Date**