SECURITY BENEFIT®

Questions? Call our National Service Center at 1-866-747-3416.

Security Benefit
Health Reimbursement Arrangement (HRA) Indiana VEBA Plan
Reimbursement Claim Form

Instructions

Use this form to request reimbursement for medical expenses or health insurance premiums for the participant or any Qualified IRS Dependent of the participant. For a definition of "Qualified IRS Dependent" see www.irs.gov.

Please type or print in black ink.

1. Complete the worksheet on this form to itemize expenses and attach original receipts.
2. Medical expense reimbursement requests must be at least $100.00 unless account balance is less than $100.00.
3. **Section 5** is required for medical reimbursement claim requests.
4. This completed form and all required attachments should be mailed to:
   Security Financial Resources
   P.O. Box 758549
   Topeka, KS 66675-8549

1. Provide Personal Information

Employer Group Name (required) Metropolitan School District of Wabash Co. Employer Plan Number (if known) 353063-01

Social Security Number _____ ❑ Check here if address has changed

Name of Employee _____ (Last) _____ (First) _____ (MI)

Mailing Address _____ (Street Address) _____ (City) _____ (State) _____ (ZIP Code)

Date of Birth _____ (Date (mm/dd/yyyy)) Date of Retirement _____ (Date (mm/dd/yyyy))

Daytime Phone Number _____ Home Phone Number _____

E-mail Address _____

2. Insurance Premium Reimbursement

Policy Holder	Named insured on policy.
Description of Policy	Example: Medical, Dental, Medicare Supplement
Policy Period	Renewal period for insurance policy. Date through which premiums are good.
Reimbursement Start Date	Date reimbursement will begin
Reimbursement End Date	Date reimbursement will end (cannot exceed 1 year)
Amount Requested	Dollar amount you are requesting to be reimbursed.
Frequency	Example: One Time; Monthly; Quarterly; Semi-Annual
Send Payment To	Example: Self; Employer; Provider
Note:	Some Insurance Providers cannot be paid directly. When the provider cannot be paid directly, payment will be made payable to the participant.

Policy Holder	Description of Policy	Policy Period	Reimbursement Start Date	Reimbursement End Date	Amount Requested	Frequency	Send Payment To
						Total	

3. Form of Payment for Medical Reimbursement

❑ Select this option if you wish to have payments from EMJAY made by direct deposit to your bank account. Proceeds will arrive within 3 business days after the withdrawal.

I hereby authorize Security Benefit to initiate credit entries to my:

❑ Checking Account ❑ Savings Account

Receipt by said bank of such credit entries shall be deemed receipt by me.

❑ Select this option if you wish to have a check mailed to you at the address provided in Section 1.

I understand that I may be assessed a $10.00 processing fee if I choose to have a check mailed to me.

Please provide your bank information below. If any information is missing your request may be delayed. You may also attach a void check to ensure necessary information is provided.

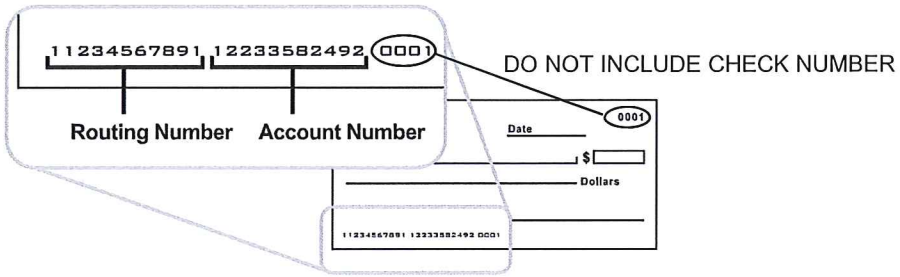
Bank Account Type (please check one): ❍ Checking ❍ Savings ❍ Information on File

Bank Name _____

Name on Bank Account _____

Bank Routing Number _____

Bank Account Number (Do not include the check number) _____



4. Provide Signatures

When filing this form, I agree:

- That this claim represents qualifying medical expenses not covered/reimbursed by insurance and that I am eligible to receive reimbursement.
- My signature below confirms my understanding and agreement with this requirement.
- I further understand that any claim that does not meet these requirements may result in this payment being considered a taxable payment by the IRS.
- I understand that the direct deposit arrangement will continue until Security Benefit receives written notification from me stating otherwise.
- I verify that I have received all eligible reimbursement under any applicable health plan or Section 125 Flexible spending account.

X_____ _____

Signature of Employee — Date (mm/dd/yyyy)

When filing for expenses *eligible under your insurance plan* (i.e. health, dental, vision, etc), *but not paid* (i.e. deductibles, coinsurance, patient's portion, etc), be sure to attach copies of the explanation of benefits (EOB), showing date of service, type of service, and the extent of reimbursement or denial of claims.

Please Continue ➲

5. Provide Summary of Itemized Medical Bills

Participant/Qualified IRS Dependent	Relationship	Description of Service	Date of Service	Amount Requested
			Total	

Eligible expenses must be submitted for reimbursement within one year of incurring the expense and generally include health care expenses that are not covered, or only partly covered, by your health plans or, if you're married, by your spouse's health plans. Some of the expenses you can claim are:

Deductibles and co-payments under medical, dental, and prescription drug plans; Expenses for medical services or supplies not covered by your plans (for example, many plans do not cover routine physical or well-child care); Vision care expenses, including eye exams, eyeglasses, as prescribed by your doctor, and materials and equipment needed for using the eyeglasses such as eyeglass cleaner, contact lenses and contact lens supplies; Lasik, Laser eye surgery and Radial keratotomy; Hearing care expenses, including hearing exams and hearing aids; Expenses in excess of medical or dental plan limits (for example, orthodontic expenses greater than the limit set by your dental plan); Transportation expenses related to medical care; Nursing services not covered by your medical plan; Wheelchairs and crutches; Capital expenses for a personal residence to accommodate a disabled condition less the increase in your property value; Pregnancy test (over the counter); Certain over the counter drugs; Over the counter reading glasses when accompanied by a prescription; Smoking cessation program; Weight loss program when it is prescribed by your doctor for a specific diagnosis; Health related insurance premiums – e.g. dental insurance, vision insurance, health insurance, Medicare supplements, Medicare Part B, long-term care insurance.

Expenses that are not Eligible

Most cosmetic surgery; Health club dues; Electrolysis; Over the counter vitamins, even when prescribed by a physician; Dietary supplements; Teeth whitening products; Life insurance premiums; or expenses not incurred within one year at the time of filing.

For expenses that are not listed you can refer to IRS Code Section 213 for more complete information or contact Security Benefit at 1-866-747-3416.

Mail to: Security Financial Resources • PO Box 758549 • Topeka, KS 66675-8549 or
Fax to: 1-785-438-4944
Visit us online at www.securitybenefit.com/Indiana • E-mail rpwf-veba@securitybenefit.com

SECURITY BENEFIT℠
To and Through Retirement

Security Benefit Health Reimbursement Arrangement (HRA) Indiana VEBA Plan

Program Summary

Type of Plan	• A model Health Reimbursement Arrangement available for adoption by public sector employers and funded through a Voluntary Employees' Beneficiary Association (VEBA) tax-exempt trust established under Section 501(c)(9) of the Internal Revenue Code.
Eligible Participants	• Public sector employees, their spouses and IRS qualified dependents

Tax Advantages	• Plan sponsor pays no FICA taxes on plan contributions
	• Participant pays no FICA, federal, or in most cases state income taxes on:
	  ○ Contributions
	  ○ Investment earnings
	  ○ Distributions for qualified health care expenses

Funding Options	• Insurance Premium Reimbursement Account
	  ○ Variable dollar contributions
	  ○ Accumulated leave (including sick and/or vacation time)
	  ○ Retirement incentives
	  ○ Percentage of pay
	• Medical Expense Reimbursement Account
	  ○ Equal dollar contributions

Eligible Expenses	• Insurance Premium Reimbursement Account
	  ○ COBRA premiums
	  ○ Dental insurance premiums
	  ○ Health insurance premiums
	  ○ Long-term-care premiums
	  ○ Medicare Part-B premiums
	  ○ Medicare supplement premiums
	  ○ Vision insurance premiums
	  ○ IRS qualified premiums for health insurance coverage
	• Medical Expense Reimbursement Account
	  ○ Qualified out-of-pocket medical expenses such as prescription drugs, eye glasses, and office visit co-pays
	  ○ COBRA premiums
	  ○ Dental insurance premiums
	  ○ Health insurance premiums
	  ○ Long-term-care premiums
	  ○ Medicare Part-B premiums
	  ○ Medicare supplement premiums
	  ○ Vision insurance premiums
	  ○ IRS qualified premiums for health insurance coverage

Distributions	• Participants may access their account upon separation from service to reimburse eligible health care expenses incurred by them, their spouse or an IRS qualified dependent • $100 minimum reimbursement – non-systematic • In-service distributions permitted in some plans. Contact your employer for details.
Investment Options	• 37 investment options with varied risk and return potential • 23 investment management firms • Fixed Account option*
Account Management Features**	• Participant investment direction • Automatic dollar-cost averaging (monthly or quarterly; $25 minimum per fund) • Automatic asset reallocation (monthly, quarterly, semiannually, annually)

Fees	• Plan sponsor
	  ○ None
	• Participant
	  ○ $20 annual administrative fee
	  ○ 0.38% asset-based fee

Death of Participant	• Any remaining account balance is immediately made available to a qualified dependent(s) to use for eligible health care expense reimbursements • If the participant does not have a surviving spouse or qualified dependent(s), the account balance is reallocated to the HRA accounts of the other plan participants within your employee group

Please Continue ➲