Automatic Premium Reimbursement *(or payment)*

Skip this form! Log in at **indianahra.com** and submit your request online.
Important reminders and information on reverse.

Indiana HRA
VEBA and 115

IN13

SUBMIT COMPLETED FORM TO:
claims@indianahra.com | Fax: (206) 577-3020 | Indiana HRA Plan, PO Box 80587, Seattle, WA 98108

Claims-eligible participants who are actively-employed and receiving monthly employer contributions must have a minimum account balance of $2,000 to begin/renew an automatic premium reimbursement.

1 PARTICIPANT ACCOUNT AND CONTACT INFORMATION

If you are claims-eligible under more than one participant account, enter the participant account number of the account from which you want your automatic reimbursement. Otherwise, your automatic reimbursement will be taken from the account with the earliest claims-eligibility date. **All information in this section is required to process your automatic premium reimbursement request.**

ACCOUNT NUMBER or SSN _____ DATE OF BIRTH mm / dd / yyyy _____

Have you previously separated or retired from the employer that made/is making contributions to this account?

☐ YES DATE OF SEPARATION or RETIREMENT mm / dd / yyyy _____
☐ NO EMPLOYER NAME _____

LAST NAME _____ FIRST NAME _____ M.I. _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

AREA CODE and PHONE NUMBER _____ EMAIL ADDRESS (use home or personal email address) _____

☐ **Check here to go green and receive e-communication.** Read details on reverse.

2 AUTOMATIC PREMIUM REIMBURSEMENT INFORMATION

You MUST attach documentation that includes: (1) name(s) of covered individuals or policy holder; (2) premium amount(s); (3) policy period; and (4) insurance provider name. This information is typically contained on your premium billing notice. If required documentation is not received, your automatic premium reimbursement request will be denied. **Premiums paid by an employer, deducted pre-tax through a Section 125 cafeteria plan or subsidized by the Premium Tax Credit are not eligible for reimbursement.** If this reimbursement request is for long-term care insurance premiums, you must include a copy of the policy's Declaration page. The Declarations page usually contains confirmation that the policy is tax-qualified.

This is a: ☐ **NEW** request ☐ **CHANGE** to existing reimbursement

Amount of each reimbursement:
NEW AMOUNT $ _____
OLD AMOUNT (if this is a change) $ _____

Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Beginning with coverage for month/year of: _____ mm / yyyy

Due date of first reimbursement: (To occur on time, request must be received at least 10 days prior to due date)
☐ 1st or ☐ 15th day of the month
☐ Please make my first reimbursement retroactive to my requested due date, if this date is in the past, or if this request is not received in time.

Is the policy in your name?
☐ YES ☐ NO If reimbursement is for policy not in your name (such as your spouse's), please list his/her name, social security number or policy number, and date of birth.

NAME _____
SSN or POLICY NUMBER _____ DATE OF BIRTH _____

Make automatic premium reimbursements payable to:
☐ Me, the participant
☐ Employer or insurance carrier as follows:

PAYEE NAME _____
PAYEE ADDRESS _____ CITY _____ STATE _____ ZIP _____

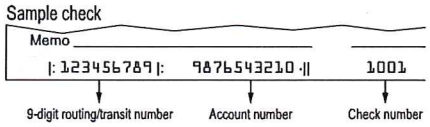
3 DIRECT DEPOSIT ENROLLMENT (RECOMMENDED)

Direct deposit is faster and more convenient than waiting to receive paper check reimbursements in the mail. Information you provide below will supersede any previous direct deposit enrollment on file. A voided check is not required.

☐ New request
☐ Use direct deposit already on file

NAME OF FINANCIAL INSTITUTION (bank or credit union) _____
☐ Checking ☐ Savings

9-DIGIT ROUTING NUMBER (see sample check) _____ ACCOUNT NUMBER (do not include check number) _____



4 REQUIRED PARTICIPANT SIGNATURE AND AUTHORIZATION

I (participant) hereby authorize the Indiana HRA Plan to disburse funds from my participant account as provided for in this form. I understand that approximately three (3) months before my account is expected to run out, any portion of my remaining account balance not already allocated to VALIC Fixed-interest Option will be transferred to protect my account against losses in case significant negative market changes occur. I hereby agree to hold my employer, the Indiana HRA Plan, and it's service providers harmless for any damages that may occur from following the instructions on this form. I hereby certify that (1) the foregoing statements are true and correct, (2) the premium amount submitted is the accurate amount of my cost of qualified insurance premiums, and (3) all such persons covered under the insurance policy are qualified dependents under the terms of the Plan, and (4) premiums for which I am requesting reimbursement are not being paid by an employer and are not eligible for pre-tax deduction through my employer's section 125 cafeteria plan. I acknowledge and agree that any claim submitted fraudulently could result in my termination from the Plan and/or other legal action. I understand that it is my responsibility to notify the Plan if my premium amount or other information changes. For direct deposits: I hereby authorize and request the Plan to electronically deposit a periodic reimbursement for my insurance premium(s) to the financial institution designated above or already on file with the Plan. This authorization is not an assignment of my right to receive payment and revokes all prior payment direction notifications. I understand funds availability is subject to my banking institution's policies and procedures. I understand the authorization(s) on this form will remain in effect with Indiana HRA Plan until my account is depleted or until cancelled by written notice from me or my power of attorney.

Required documentation attached? ☐ YES ☐ NO

Sign Here ▶ X _____
PARTICIPANT SIGNATURE _____ DATE mm / dd / yyyy _____ PHONE NUMBER WHERE I CAN BE REACHED _____

QUESTIONS? 1-888-711-9182 | customercare@indianahra.com | indianahra.com

Important reminders on reverse ▶

For new automatic premium reimbursements

Step 1: Be sure to attach the required documentation as described in section 2 when submitting this form.

Step 2: Long-term care reimbursements must be for tax-qualified long-term care coverage and are subject to annual IRS limits. You must include a copy of your policy's Declarations page that confirms the policy is tax-qualified.

After initial set-up

- When your premium amount(s) change, or if you are no longer paying the premium, it is your responsibility to notify us to adjust your automatic premium reimbursement amount. Failure to update this information may result in your reimbursement no longer being a valid reimbursement exempt from taxation. Changes must be received 10 calendar days prior to due date.
- Be sure to notify us if your mailing address changes.
- Approximately three (3) months before your account is expected to run out, any portion of your remaining account balance not already allocated to VALIC Fixed-Interest will be transferred to protect your account against losses in case significant negative market changes occur. Notification will be sent to you. The VALIC Fixed-Interest fund is Indiana HRA's most conservative investment.

E-Communication

E-communication is fast and convenient. Electronic documents may include your Plan Summary, participant account statement and explanation of benefits (EOB) notifications, and general communication. If you are electing e-communication, please note that after logging in to your account at **indianahra.com**, you (1) may withdraw your consent for electronic documents at any time without charge by updating your account preferences; (2) will be able to view and print copies of electronic documents (you may request paper copies at no charge by contacting the customer care center); and (3) can update your email address on file by updating your personal information. To access electronic documents, you will need a copy of Adobe Acrobat Reader software loaded on your computer. You can download and install a free copy at www.adobe.com. Documents provided electronically will not be mailed via U.S. Mail.

Claim Form

Use this form for **Medical Expense Reimbursement**

Indiana HRA
VEBA and 115

IN15 (1/17 PRC)

Skip this form! Log in at **indianahra.com** to submit your claims online.

Submit paper forms to: claims@indianahra.com | Fax: 206-577-3020 | Indiana HRA, PO Box 80587, Seattle, WA 98108

☑ Make sure your documentation has everything it needs!

Make sure you attach proof of each expense. Missing, incomplete, or illegible supporting documents are the most common reasons claims are denied. For guidelines on how to submit "clean" claims, read our **Secret to Quick Reimbursements** and **How to File a Claim** handouts. You can help avoid denied claims by making sure the proof you submit is legible and contains all five of the following:

- ☐ **Name** of covered individual
- ☐ **Date** item was purchased or service was provided
- ☐ **Service Provider** name (e.g., doctor, pharmacy, hospital, etc.)
- ☐ **Description** of the item purchased or service received
- ☐ **Amount** of out-of-pocket expense

Cancelled checks, carbon copy checks, credit or debit card receipts, bank statements, and balance forward or payment on account statements do not contain all of the required information and are not acceptable. Common forms of documentation include:

1. **Explanation of benefits (EOB)** from your insurance company (recommended);
2. **Itemized statement** of services from your doctor or other service provider;
3. **Stub** from a prescription (not the cash register receipt); or
4. **Detailed receipt and prescription** for over-the-counter medicines.

Get your qualified insurance premiums reimbursed automatically!

You do not have to submit a claim every month for your qualified insurance premiums. Set up an **automatic premium reimbursement (APR)**. To set up an APR, you can either log in online or complete and submit a paper **Automatic Premium Reimbursement** form. IRS regulations prohibit us from reimbursing insurance premiums that are paid by an employer, deducted pre-tax through a Section 125 cafeteria plan, or subsidized by the premium tax credit. To learn more, read **Premium Tax Credit and Your HRA** in the **Plan Summary**.

Easy ways to get your money back faster!

The best way to get your money back fast is to file your claim **online** or use our mobile app, **HRAgo®**. Simply log in at **indianahra.com** to log into your online portal. You can download HRAgo from the App Store or Google Play. To use HRAgo, you must be registered for online account access.

E-communication

Elect e-communication to avoid paper communication! If you have elected e-communication, please note that after logging in at **indianahra.com**, you (1) may withdraw your consent for electronic documents at any time without charge by updating your account preferences; (2) will be able to view and print copies of electronic documents (you may request paper copies at no charge by contacting the customer care center); and (3) can update your email address on file by updating your personal information. To access electronic documents, you will need a copy of Adobe Acrobat Reader software loaded on your computer. You can download and install a free copy at www.adobe.com. Documents provided electronically will not be mailed via U.S. Mail.

Need a form or any of the resources listed above? Log in at **indianahra.com** and click **Resources** on the menu bar.

IN15

1 PARTICIPANT ACCOUNT AND CONTACT INFORMATION

If you have more than one claims-eligible account, enter the participant account number of the account from which you want to be reimbursed. Otherwise, your claim will be reimbursed from the account with the earliest claims-eligibility date.

ACCOUNT NUMBER or SSN _____ DATE OF BIRTH mm / dd / yyyy _____

LAST NAME _____ FIRST NAME _____ M.I. _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

AREA CODE and PHONE NUMBER _____ EMAIL ADDRESS (use home or personal email address) _____

☐ Check here to avoid paper and receive e-communication.

IMPORTANT: Have you previously separated or retired from the employer that made/is making contributions to this account?

☐ YES
☐ NO DATE OF SEPARATION or RETIREMENT mm / dd / yyyy _____ EMPLOYER NAME _____

2 IMPORTANT: READ BEFORE SUBMITTING

By completing and submitting this form, you certify to all of the following:

- The information provided in this reimbursement request or documentation submission is true and correct and any claim submitted fraudulently could result in your termination from the Plan and/or other legal action
- The submitted expense has not been reimbursed and is not reimbursable from any other source
- The covered individual identified below meets the Plan requirements for coverage under the Plan
- Claims or transactions for group medical premiums have not been paid by an employer, and are not eligible for pre-tax deduction through your employer's section 125 cafeteria plan
- You understand that (1) premiums for marketplace exchange coverage are not qualified for reimbursement **if you are receiving or will be claiming the premium tax credit** and that (2) your claims-eligible HRA may prevent you from becoming eligible for the premium tax credit. To learn more, read **Premium Tax Credit and Your HRA** in the **Plan Summary**
- The Plan and its agents cannot guarantee any federal or state tax results or investment results. Any benefits to which you may become entitled are subject to the terms and conditions of the governing Plan documents and applicable law. The Plan and its agents may withhold from such benefits (and may transmit to the government if required by law) any tax, charge, penalty, assessment, or other amount that is determined to be attributable to or allocable to such benefits or on account of the operations of the Plan. You agree to hold the Plan, the employer, and their agents harmless for any loss, liability, or damages that may arise from the employer making contributions to the Plan, with respect to such withholding or any failure to withhold or pay such amounts, and any other actions taken in good faith for the operation of the Plan
- If you are currently employed with the employer who established this HRA account, you certify that you are not seeking reimbursement for individual marketplace healthcare coverage
- **The following certifications are for medical expenses** (does not include dental, vision, and tax-qualified long-term care expenses or premiums):
  - **In-service HRA Plan Participants Who Are Still Employed:** For spouse or dependent claims, your spouse or dependent was covered by an employer-sponsored group health plan at the time any of the medical expenses (other than dental, vision, or qualified long-term care) in section 3 were incurred.
  - **Post-separation HRA Plan Participants:** If this claim is to be reimbursed from a post-separation HRA account, you were not employed (or re-employed) by the employer that made or is making contributions to your account on the date any of the medical expenses listed in section 3 were incurred.

3 EXPENSE INFORMATION

If this form is for a covered individual other than yourself, make sure to include the individual's name, full Social Security number, and date of birth below.

Expense Reimbursements		
Covered Individual	Date of Service	Expense Amount
If not for yourself, for your: ☐ Spouse ☐ Dependent		
Name: _____		
SSN: _____ **DOB:** _____		
If not for yourself, for your: ☐ Spouse ☐ Dependent		
Name: _____		
SSN: _____ **DOB:** _____		
If not for yourself, for your: ☐ Spouse ☐ Dependent		
Name: _____		
SSN: _____ **DOB:** _____		

Have more expenses? Include an itemized list on a separate sheet of paper and write the total amount in the "expense amount" column on the first row.

Claims

How to File a Claim

After enrolling and becoming claims-eligible, most participants can submit claims and supporting documentation (proof of expense) online after logging in or via our mobile app, HRAgo®.

If you prefer, you can submit a paper **Claim Form** via e-mail, regular mail, or fax as indicated on the form (faxing is sometimes unreliable and is not recommended). Detailed instructions are contained on the backside of the form. The Claim Form is available from this site under Forms, after logging in or upon request from our customer care center.

You may request reimbursement of qualified medical care expenses and/or insurance premiums you have incurred on behalf of yourself, your legal spouse, and your qualified dependents. Qualified expenses and premiums submitted for reimbursement must have been incurred after you became a participant and eligible to file claims.

IRS rules require that you include proper proof of each expense. Missing, incomplete, or illegible forms of documentation are the most common reasons claims are denied. You can help avoid denied claims by making sure the proof you submit is legible and contains all of the following:

1. **Name** of patient or covered individual who received the item or service;
2. **Date** item was purchased or service was provided;
3. **Service Provider** name (e.g. doctor, pharmacy, hospital, etc.);
4. **Description** of the item purchased or service received; and
5. **Amount** of out-of-pocket expense.

Generally, all of the information we need is contained on any one of the following types of documents:

1. **Explanation of benefits (EOB)** from your insurance company (recommended);
2. **Itemized statement** of services from your doctor or other service provider;
3. **Stub or "bag tag"** from a prescription (not the cash register receipt); or
4. **Detailed receipt and prescription** for over-the-counter (OTC) medicines.

Please note the following:

1. IRS regulations provide that insurance premiums paid by an employer, deducted pre-tax through a section 125 cafeteria plan, or subsidized by the Premium Tax Credit are not eligible for reimbursement. If requesting reimbursement of premiums deducted from your paycheck after tax, you must include a letter from your employer that confirms no pre-tax option is available. Qualified insurance premiums deducted from your legal spouse's paycheck after tax are eligible for reimbursement.
2. If you or your legal spouse has a section 125 healthcare flexible spending account (FSA), you must exhaust the FSA benefits before submitting claims to your HRA.
3. Claims for over-the-counter (OTC) medicines and drugs (except insulin and contact lens solution) must be prescribed by a medical professional or accompanied by a note from a medical practitioner recommending the item or service to treat a specific medical condition. Thus, OTC medicines and drugs such as aspirin, antihistamines, and cough syrup must be prescribed. The prescription requirement applies only to medicines and drugs, not to other types of OTC items such as bandages and crutches.

Read our **How to File a Claim** handout to learn more. To get a copy, log in and click **Resources**, or request a copy from our customer care center.

Automatic Premium Reimbursements

After enrolling and becoming claims-eligible, you can set up automatic reimbursement of ongoing qualified insurance premiums on behalf of yourself, legal spouse, and qualified dependents. Automatic premium reimbursements can be set up online (recommended) after logging in.

If you prefer, you can submit a paper **Automatic Premium Reimbursement** form via e-mail, regular mail, or fax as indicated on the form. Instructions are contained on the form. Forms are available after logging in or upon request from the customer care center.

You must provide supporting documentation that includes:

1. Name(s) of covered individuals or policy holder;
2. Premium amounts;
3. Policy period; and
4. Insurance provider name.

This information is typically contained on your premium billing notice, statement of insurance, open enrollment notice, pension benefit direct deposit stub, or similar form of documentation.

Please note the following:

1. IRS regulations provide that insurance premiums paid by an employer, deducted pre-tax through a section 125 cafeteria plan, or subsidized by the Premium Tax Credit are not eligible for reimbursement. If requesting reimbursement of premiums deducted from your paycheck after tax, you must include a letter from your employer that confirms no pre-tax option is available. Qualified insurance premiums deducted from your legal spouse's paycheck after tax are eligible for reimbursement.

2. Claims-eligible participants who are actively-employed and receiving monthly employer contributions must have a minimum account balance of $2,000 to begin or renew an automatic premium reimbursement (or payment).