

**Skip the form!**

Log into your account at **portal.yourwaybenefits.com** to submit your claim and your supporting documentation online.

To submit this paper form, follow instructions provided below and send to: **YourWay Benefits, PO Box 4391 Clinton, IA 52733-4391.**



**1 Participant Information (Please fill out your information below.)**

Participant Number or SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ Is this a new address?: ☐

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**2 Required Supporting Documentation**

Please provide copies of documentation for expenses that are eligible for reimbursement. Certain expenses may require a Letter of Medical Necessity from your doctor. Please ensure that your documentation is legible (no highlighting) and contains the following 5 items:

1. Provider Name
2. Patient Name
3. Date of service
4. Description of service or item (Canceled checks, balance forward statements, and credit card receipts are NOT acceptable).
5. Amount incurred by Patient

**3 Expense Information**

| Covered Individual                                                                                                                                        | Date of Service | Expense Amount |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|----------------|
| <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent<br>Spouse/Dependent Name: _____<br>SSN: _____ DOB: _____ |                 |                |
| <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent<br>Spouse/Dependent Name: _____<br>SSN: _____ DOB: _____ |                 |                |
| <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent<br>Spouse/Dependent Name: _____<br>SSN: _____ DOB: _____ |                 |                |

**4 Required Participant Authorization and Certification**

By completing and submitting this form, you certify that: (1) all information provided in this submitted claim is true and correct; (2) the amount of this submitted claim is an accurate statement of your (a) unreimbursed medical/dental/vision expenses after payment by insurance (if any) and/or (b) medical/dental/vision/tax-qualified long-term care insurance premiums; and (3) the submitted claim is not reimbursable from any other source.

Spouse and Dependents: With respect to claims submitted on behalf of qualified dependents, you also certify that (1) such persons meet each individual meets the Plan requirements and are qualified dependents as defined under the terms of the Plan and (2) any major medical expense or premium (not including expenses for dental, vision, or tax-qualified long-term care) each individual was incurred either (i) while he or she was covered by an individual coverage health plan or an employer-sponsored group health plan or (ii) while you were separated or retired (not employed or re-employed) from the employer who provided your my benefits account.

If you are adding a spouse or one or more dependents in Section 2 above, you "I certify that the covered individual I am adding is enrolled in or covered by an individual coverage health plan or an employer-sponsored group health plan and meets all other eligibility requirements for the Plan. I acknowledge that with each claim for reimbursement (or each benefit card transaction) for a major medical expense or premium (other than dental, vision, or qualified long-term care expenses and premiums) that this covered individual must be enrolled in or covered individual coverage health plan or an employer-sponsored group health plan at the time expense is incurred."