SECURITY BENEFIT

HEALTH REIMBURSEMENT ARRANGEMENT ACCOUNT

VEBA HRA

CHECKLIST FOR SUBMITTING CLAIMS

Eligibility for reimbursement

The coverage period begins when the participant becomes eligible for benefits. Expenses must be incurred after the participant is eligible and when the service is provided, not when the expense is billed, charged, or paid. Request for reimbursement must be submitted within **one year** from when the expense was incurred.

Substantiating claims

The IRS mandates that participants within an HRA plan must provide substantiation for claims submitted under the plan. Claim amounts from health care providers will be considered after all insurance has paid. To have your claim processed in a timely manner, you must provide the following:

- HRA claim form, filled out in its entirety and signed
  - Medical requests must have an itemized statement or an explanation of benefits from your health care provider that must include:
    - The name and address of the provider
    - Date of service
    - Who received the service
    - Description of service
    - Amount owed for services
  - Insurance premium payment – a current invoice or billing is required from the Provider/Carrier/Policyholder. The invoice must contain a Description of Policy; Amount of Premium; Frequency of Premium; Name of Person Receiving Coverage; Date of Coverage. The IRS allows premiums to be setup for reoccurring payments up to 12 months. This must be indicated on the claim form when submitted.

If your initial submission does not contain all of the required documentation, your reimbursement may be delayed.

Submitting claims

You may submit your claim form and substantiation to:

Fax: 866.477.6526

E-mail: EBWF@securitybenefit.com

Or mail to:

Security Financial Resources
PO Box 750600
Topeka, KS 66675-0600

Mifflinburg Retiree
Security Benefit
Direct Dial Phone #
888-473-5572

SECURITY BENEFIT®

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Questions? Call our National Service Center at 1-800-888-2461.

Security Benefit
Group Healthcare Reimbursement Account (HRA)
Reimbursement Claim Form

Instructions

Use this form to request medical expense reimbursement following severance from employment. Complete the entire form. Please type or print

1. Complete the worksheet on the back of this form to itemize expenses and attach original receipts.
2. Medical expense reimbursement requests must be at least $100.00.
3. Completion of **Section 5** is a requirement for filing and will speed the processing of your claim.
4. This completed form and all required attachments should be mailed to:
   Security Benefit
   P.O. Box 750600
   Topeka, KS 66675-0600

1. Provide Personal Information

Plan Number _____ Employer Name _____

Name of Employee _____ _____ _____
First MI Last

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

Social Security Number _____ E-mail Address _____

Daytime Phone Number _____ Home Phone Number _____

2. Select Type of Claim

Please select one:

❍ **Insurance Premium Reimbursement**

Requested Amount: $ _____

❍ Monthly ❍ One time

If Monthly Indicate Date: _____
(Day of month – must be between the 2nd and the 28th of the month)

Duration _____
(Up to 12 months)

❍ **Medical Expense Reimbursement**

Requested Amount: $ _____

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.

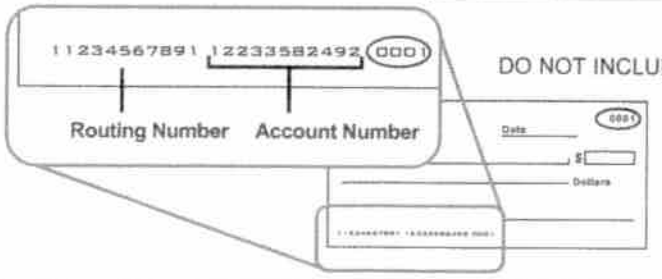
Bank Account Type (please check one): ❍ Checking ❍ Savings

Bank Name _____

Name on Bank Account _____

Bank Routing Number _____

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



3. Provide Payment Options

❑ Select this option if you wish to have payments from Security Benefit 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.

A processing fee of $2.50 per check may be added to claim amount, depending on your plan, if you do not wish to be reimbursed through direct deposit processing.

❑ Requesting **check** payment option.

4. Provide Signatures

I agree:

- That this claim represents qualifying medical expenses not covered/reimbursed by insurance and that I have severed my employment with the employer sponsoring this plan.
- 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.

X_____ _____

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

5. Provide Summary of Itemized Bills

Name of Physician, Hospital Pharmacy or other Provider of Service	Description of service, if drug include name, days supply and quantity	Patient Name	Relationship	Amount of Charge

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; Disability insurance premiums; or 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 Section 213 for more complete information or contact Security Benefit at 1-800-888-2461.