ACCOUNT RULES AND CLAIM FILING INSTRUCTIONS FOR HEALTH REIMBURSEMENT ARRANGEMENTS

INSTRUCTIONS

1. Complete ALL information on the claim form for each amount claimed for reimbursement.

   Incomplete forms will be returned. This includes for lack of SSN, for example.
2. Attach copies of required documentation to the claim (See Required Documentation below for information)
3. Sign and date the claim
4. Make a photocopy of the claim for your records
5. Submit the claim with attached recipes via fax, email or mail. *Please limit faxed claims to 9 pages or less.*

REQUIRED DOCUMENTATION

Medical procedures (including doctor visits, labs, surgery, etc.): Please submit an Explanation of Benefits (EOB) from the insurance company.

- EOBs are required for expenses other than co-pays.
  - EOBs will need to reflect the date of service, services rendered, total cost of procedure, total insurance coverage and total patient responsibility.
- If your HRA covers expenses not covered by your health insurance, you may submit an itemized statement.
  - Itemized statements must include name of the patient and provider, date of service, type of service/supply, and charge. (Balance forward, previous balance, credit card receipts, canceled checks or account statements are ***not*** sufficient documentation.)

P.O. Box 520, Euless, TX 76039 Phone: (817) 731-6258
Fax: (972) 470-9392 Email: claims@abybenefits.com Website: www.abybenefits.com

HEALTH REIMBURSEMENT ARRANGEMENT REQUEST FORM

NAME_____ EMPLOYER_____ SSN _____-_____-_____

HOME (MAILING) ADDRESS_____ CITY_____ STATE_____ ZIP_____

☐ *check here if your address has recently changed*

EMAIL ADDRESS _____@_____ DAY PHONE (_____) _____-_____ (optional)

Do you have coverage for medical expenses?	Yes ☐ No ☐	Was the amount applied to your deductible?	Yes ☐ No ☐
Do you have coverage for dental expenses?	Yes ☐ No ☐	Was the amount you paid a co-payment?	Yes ☐ No ☐
Is any portion of the service covered by your insurance?	Yes ☐ No ☐	Is your proof of expense attached?	Yes ☐ No ☐
Is your EOB attached? (if applicable)**	Yes ☐ No ☐		

SUMMARY OF EXPENSES				Dates the service incurred		Payment
Name of person receiving services	Relationship to Employee	Provider of Services	Nature of Expense	From MM/DD/YY	To MM/DD/YY	Amount $$$ (check box if *my*Source card used)
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
****An EOB is required for expenses other than co-pays. Claims must be filled out completely and received by 12:00pm prior to the processing day in order to obtain reimbursement during the next processing cycle.**					**TOTAL**	

I (above named Participant) understand and agree that:

- These expenses are not reimbursable from any other health plan, insurance or other source, and will not be used to claim any federal income tax deduction or credit.
- The Unreimbursed Medical expenses listed above would be deductible medical expenses under Internal Revenue Code Section 213 and are allowed under Prop. Treas. Reg. 1.125-2;
- If the expense is for my spouse or dependent, I certify that the person listed is my spouse or meets the definition of dependent under the plan as defined in Code Section 152;
- By submitting this information (via fax, e-mail, or any other media), I am responsible for any inappropriate use or disclosure that may occur due to incorrect or inaccurate transmissions;
- I authorize the Plan and its service provider, their respective agents, employees, sub-contractors and assigns to use and/or disclose the information provided above as they reasonably deem necessary to manage the Plan (including but not limited to, disclosures to my employer for Plan Administration purposes such as the evaluation of eligibility for reimbursement under the Plan) and to detect or prevent fraud or misrepresentation;
- I authorize any provider, insurer, or other entity to release any health or treatment information for the purpose of determining eligibility for Plan benefits or to detect or prevent fraud;
- I give up any claims related to the use, disclosure, or release of this information so long as the information is used for the purposes defined above; and
- This authorization does not in any way limit any right that ER/PSP, their respective agents, employees, sub-contractors, and/or any assigns may have under applicable state or federal law or regulation regarding the use of such information.

EMPLOYEE SIGNATURE: _____ DATE: _____