Surency FLEX

HRA RECURRING PREMIUM REIMBURSEMENT REQUEST FORM

A new form needs to be submitted for each Plan Year.

Last Name, First Name, MI (Please Print) _____

Employer _____

Social Security Number or Employee ID _____

Mailing Address _____

City, State, ZIP _____

☐ Check if NEW ADDRESS

Home Address *(if different)* _____

City, State, ZIP _____

Recurring Reimbursement

Covered Person & Relationship (Spouse, Child, etc.)	New Expense/ Expense Change/ Expense End	Type of Premium (Medicare Part B or D, Medigap, Group Health Plan, Dental, TRICARE, etc.) if applicable	Coverage Start Date (MM/DD/YYYY)	Coverage End Date (MM/DD/YYYY)	Monthly Amount Requested

Attach copies of your Insurance Provider/Carrier statement(s) or receipts. Copies must include the date(s) of coverage. Please do not send originals of your insurance statements - keep originals for your records.
Missing information may delay the processing of your reimbursement.

Reimbursement Guidelines

1. The reimbursement request must be an IRS eligible expense incurred during the Plan Year.
2. The reimbursement request must not have been previously reimbursed nor are you seeking reimbursement from any other source(s).
3. Attach a copy of your insurance Provider/carrier statement(s) for the coverage period or a copy of your "Notice of Medical Insurance Enrollment and Premium Deduction", also called "Proof of Income" letter. This is provided by the Department of Health and Human Services (HHS).
4. Information Provided must include the following:
   - Covered Individual's Name
   - Name of the Insurance Carrier
   - Address of the Insurance Carrier
   - Date(s) of Coverage
   - Premium Amount

Note: Canceled checks, credit card receipts or statements that only show "Balance Due" are not acceptable forms of substantiation.

Signature

I hereby certify that the reimbursement requests I am submitting are IRS eligible expenses, and to the best of my knowledge, the expenses listed above are accurate and complete. I have not been previously reimbursed for these expenses under this plan, any other plan, nor am I seeking reimbursement for these expenses from any other source. I also understand that Surency, its agents or employees, will not be held liable if I submit non-IRS eligible expenses for reimbursement. I understand that the expense for which I am reimbursed may not be used to claim any federal income tax deduction or credit and that they were incurred for me or my eligible dependents. Upon receiving notice of a change in premium or cancellation of coverage, I will notify Surency immediately.

Employee's Signature *(Request cannot be accepted without participant's signature)* _____

Date _____

Return completed form back to Surency at email: flex@surency.com - fax: 316-272-4841
or mail: P.O. Box 789773, Wichita, KS 67278-9773
866-818-8805 • Surency.com