

FLEXIBLE SPENDING ACCOUNT/ HEALTH REIMBURSEMENT ARRANGEMENT CLAIM FORM



FSA/HRA GUIDELINES

It sure is easy.

This document will help you submit a claim for reimbursement from your FSA or HRA.

Did You Pay Out-of-Pocket for an Eligible Expense?

Submit a claim to get paid back using money from your account. There are three ways to submit a claim:

1. SURENCY FLEX APP

Download the Surency Flex mobile app and submit the claim by taking a photo of your receipt.

2. MEMBER ACCOUNT AT

SURENCY.COM

Log into your Member Account at Surency.com to upload your receipt.

3. PAPER CLAIM FORM

Fill out this form and return to Surency via...

Email: flex@surency.com

Fax: 316-272-4841

Mail: P.O. Box 789773, Wichita, KS
67278-9773

Want to Get Paid Back Automatically?

Sign up for Direct Deposit so that after you submit a claim, Surency will automatically deposit those dollars back into your bank account. There are two ways to set up Direct Deposit:

1. MEMBER ACCOUNT AT SURENCY.COM OR VIA THE SURENCY FLEX MOBILE APP*

Log in to your Member Account at Surency.com or use the Surency Flex mobile app to input your bank account information. Adding your bank account information through either your Member Account or mobile app is quick and simple, your account will be automatically verified through a secure process.

**Recommended best practice*

2. PAPER DIRECT DEPOSIT FORM

Visit Surency.com to download a Direct Deposit form. Complete and return to Surency. *Please note, if you submit your bank account information via the paper form, further action is required in order to successfully activate direct deposit with Surency Flex. After your completed form has been received by Surency Flex, you will be required to manually verify your bank account through your Surency Flex Member Account or the Surency Flex mobile app. More information on this verification process is provided on the Direct Deposit form.*

Did You Pay for Parking or Drive to a Medical Appointment?

You can be reimbursed from your FSA for mileage and parking expenses for any travel to or from your doctor, dentist, pharmacy, or other medical care provider. Use the chart on the next page to calculate your medical mileage reimbursement amount.

For Future Purchases Use Your Surency Flex Benefits Card to Pay for Expenses

Your Surency Flex Benefits Card is a special-purpose Visa® Card that gives you an easy, automatic way to pay for eligible expenses. The Benefits Card lets you electronically access the pre-tax amounts set aside in your Surency Flex accounts. Use it when paying for eligible expenses at a provider or merchant that accepts Visa Cards and uses an inventory control system. These transactions may be automatically substantiated, meaning you don't have to file a claim and may not have to submit a receipt. However, always keep all documentation for tax purposes or in case Surency requests further documentation.



How to Use Your Card:

1. Have the cashier ring up all of your items together.
2. When it's time to pay, swipe your Surency Flex Benefits Card first. Select 'credit' and sign for your purchase. Optional: In addition to your signature, for added security you can set up a PIN number to access your funds by calling 866-898-9795. If you have a PIN number, select 'debit' and enter your PIN.
3. All eligible expenses will be paid for from your account and deducted from your total.
4. If you are purchasing non-eligible items, you will need to have a second form of payment available for those items.
5. Keep your receipts in the event that further validation is needed.

866-818-8805 • Surency.com

Last Name, First Name, MI (Please Print)

Employer

Social Security Number or Employee ID

Mailing Address

City

State

ZIP

Home Address (if different)

City

State

ZIP

☐ Check if NEW ADDRESS

Requesting Reimbursement from?

☐ Health Care FSA

☐ HRA

Comments/Special Instructions: _____

Health Care FSA or HRA Claim Details

Date Medical Care Received	Merchant/Provider Name	General Medical Expense/Item Description	Name of Person Receiving Service/Product	Claim Amount (Amount you Paid for Item/Service)	Medical Mileage 2024: \$0.21/mile	Parking Cost	Total Amount Paid
					_____ miles x _____ = _____		
					_____ miles x _____ = _____		
					_____ miles x _____ = _____		
					_____ miles x _____ = _____		
GRAND TOTAL: (add green columns together)							

Attach copies of Explanation of Benefit (EOB) statement(s) or provider receipts if there is no insurance. Copies must include the date(s) of service. Please do not send originals of your EOB's or your insurance statements - keep originals for your records. A signed Letter of Medical Necessity from your provider may also be required if the expense is considered "dual purpose." Dual purpose is defined as those items that have both a medical purpose and a personal/cosmetic or general health purpose. **Missing information may delay the processing of your reimbursement.**

Reimbursement Guidelines

1. The reimbursement request expense must be an IRS eligible expense and incurred during the Plan Year. (Claims for future dates of service are not eligible for reimbursement.)
2. The reimbursement request must not have been previously reimbursed nor are you seeking reimbursement from insurance or any other source.
3. Attach a copy of your insurance company's Explanation of Benefits (indicating date of service), or copies of receipts/bills if there is no insurance coverage to document the amounts.
4. The medical mileage indicated must be for transportation primarily for and essential to medical care and associated with the dates of service identified above. The standard medical mileage rate is set by the IRS annually and will be calculated by Surency when determined eligible expenses for unreimbursed medical expenses.

IRS Documentation Requirements:

Each item claimed must be supported with proper documentation, otherwise your claim will not be processed. The following should be included with each piece of documentation submitted to Surency with your completed claim form:

- Name of Provider
- Type of Service/Expense
- Date of Service/Expense
- Dollar Amount of Service/Expense
- Prescription and Name of Drug (if applicable)
- Please Note: Credit card receipts or canceled checks are not eligible documentation per the IRS and cannot be accepted.

Generally, reimbursement requests will not be considered for reimbursement later than 90 days from the end of your company's Plan Year. For specific guidance, please contact Surency at 866-818-8805.

The description of the service or care can be as generic as "co-pay" or "office visit."

Keep copies of each receipt and claim form for your tax purposes.

I hereby certify that the reimbursement requests I'm submitting are IRS eligible expenses and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement for these expenses from insurance or 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. **(Request cannot be accepted without participant's signature.)**

Employee'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**

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