HEALTH SAVINGS ACCOUNT DISTRIBUTION/ HEALTH REIMBURSEMENT ARRANGEMENT CLAIM FORM

Surency FLEX

HSA/HRA GUIDELINES

It sure is easy.

This document will help you submit a distribution request/claim for reimbursement from your Surency Flex Health Savings Account (HSA) and/or your Surency Flex Health Reimbursement Arrangement (HRA).

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

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

1. **SURENCY FLEX APP**
   Download the Surency Flex mobile app.
2. **MEMBER ACCOUNT AT SURENCY.COM**
   Log into your Member Account at Surency.com.
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 distribution request/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.*

HSA & HRA Reimbursement Guidelines

Please review these guidelines before completing the HRA Claim Information section on page 2 and the HSA Distribution Information section on page 3.

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.

HRA Requirements for Reimbursement

1. 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.
2. 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.

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HEALTH SAVINGS ACCOUNT DISTRIBUTION/ HEALTH REIMBURSEMENT ARRANGEMENT CLAIM FORM

Accountholder Name (Last, First, Middle Initial)

Member Information

Employer Name

Employee ID Number

Accountholder Name (Last, First, Middle Initial)

Social Security Number

Physical Address (Cannot be a PO Box)

City, State, ZIP

Phone Number

Email Address (required)

Comments/Special Instructions:

HRA Claim Information

Please complete the chart below with information about your HRA claim. The description of the service or care can be as generic as "co-pay" or "office visit." Please keep copies of each receipt and claim form, for your tax purposes.

Date Medical Care Provided	Merchant/Provider Name	General Medical Expense/Item Description	Name of Person Receiving Service/Product	Claim Amount (Amount you Paid for Item/Service)	Medical Mileage 2023: $0.22/mile	Parking Cost	Total Amount Paid
					_____ miles x $0.22 = $ 0.00		$ 0.00
					_____ miles x $0.22 = $ 0.00		$ 0.00
					_____ miles x $0.22 = $ 0.00		$ 0.00
					_____ miles x $0.22 = $ 0.00		$ 0.00
				GRAND TOTAL: (add green columns together)			$ 0.00

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.

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.

HEALTH SAVINGS ACCOUNT DISTRIBUTION/ HEALTH REIMBURSEMENT ARRANGEMENT CLAIM FORM

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Accountholder Name (Last, First, Middle Initial)

HSA Distribution Information

Request Amount $: _____ Type of Payment: If you *are not* currently enrolled in Direct Deposit with Surency Flex, you will receive a check (fee of $2.50 will be charged).

If you *are* currently enrolled in Direct Deposit wth Surency Flex, funds will be directly debited into your account. (You can sign up for Direct Deposit within your Member Account at Surency.com or via the Surency Flex mobile app.)

Select one of the following:

- ☐ **Normal -** For payments of qualified medical expenses. Save your receipts.
- ☐ **Disability -** If the disability renders you unable to engage in any substantial gainful activity and it is medically determined that the condition will last continuously for at least 12 months or lead to death. Disability distributions are subject to ordinary income tax.
- ☐ **Prohibited Transaction -** Use of HSA funds for anything other than a qualified medical expense; if not corrected in a timely manner, IRS penalties may be imposed.
- ☐ **Excess Contribution Removal -** Amount of excess contribution $: _____
  Date excess contribution occurred: _____
- ☐ **Rollover to Accountholder -** Check will be made payable to HSA Accountholder and mailed to your address on file. NOTE: IRS limits the number of rollovers that may be taken, how quickly rollovers must be completed and how the trustee or custodian must report the transaction. If you need additional information, please contact your tax advisor. By selecting this option, you are certifying to the bank that you have satisfied the rules and conditions applicable to your rollover and that you are making an irrevocable election to treat the transaction as a rollover. The funds you receive from the distribution of an HSA must be deposited into another HSA within 60 days from when you receive them. You are entitled to one distribution per year per HSA which may be rolled over. You are entitled to roll over the same assets only once in a twelve-month period.
- ☐ **Transfer to Custodian -** Transfer Check Payable to: _____
  Mail Check to: _____

Will this close your HSA?

- ☐ **Close HSA** - By checking this box I understand that my available balance, less a $25.00 fee, will be distributed.
- ☐ **No, this will not close my HSA.**

Authorization

I certify that I am the Accountholder or an individual authorized to execute this transaction. I have read and understand the instructions and any rules or conditions relating to this transaction. I assume full responsibility for this transaction and will not hold Surency or WEX Inc. liable for any adverse consequences that may result. I have not received tax or legal advice from Surency or WEX Inc. and, if necessary, will seek the advice of a tax or legal professional to ensure my compliance with related laws. All information provided by me is true and correct and may be relied upon Surency and WEX Inc.

_____ _____

Accountholder'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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