

# TRAVEL BENEFIT PLAN CLAIM FORM



## TRAVEL BENEFIT PLAN GUIDELINES

*It sure is easy.*

This document will help you submit a claim for reimbursement from your Travel Benefit Plan.

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

Submit a claim to get paid back using money from your Plan. 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 to Travel Over 100 Miles From Your Home to Obtain Health Care?

You can be reimbursed for IRS-eligible expenses for any travel to or from your health care provider or travel to obtain other health care services. Use the chart on the next page to calculate your medical mileage reimbursement amount.

### Member Information

\_\_\_\_\_  
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

Comments/Special Instructions: \_\_\_\_\_

**Please provide proof of home address. Examples of adequate documentation include: utility bill, copy of driver's license showing the home address, etc.**

**866-818-8805 • Surency.com**

## Travel Claim Details

Date Medical Care Provided	Travel Expense Description	Name of Person Receiving Service/Product	Claim Amount (Amount you Paid for Item/Service)	Medical Mileage 2022: \$0.22/mile	Parking Cost	Total Amount Paid
				_____ miles x _____ = _____		
				_____ miles x _____ = _____		
				_____ miles x _____ = _____		
				_____ miles x _____ = _____		
<b>GRAND TOTAL:</b> (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 be required if the expense is considered "dual purpose." Dual purpose is defined as those items that have both a medical purpose and a 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.

### 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
- 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.\***

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

## Authorization

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 employee's signature.)**

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

**Return completed form back to Surency at email: [flex@surency.com](mailto:flex@surency.com) - fax: 316-272-4841  
or mail: P.O. Box 789773, Wichita, KS 67278-9773**

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