EXPENSE REIMBURSEMENT VOUCHER FOR HEALTH FLEXIBLE SPENDING ACCOUNT (HEALTH FSA) OR HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Name of Employee (Last, First, MI)		Social Security #
Mailing Address ☐ *Check here if this is a new address; if so, do you have other AF products?*	**E-mail address**	
Name of Employer		**Daytime Phone #**

Date of Expense	Name of Person for Whom the Expense Was Incurred	For an HRA expense, if this person is or has ever been enrolled in Medicare, you must provide this persons Medicare Claim Number (HICN)*	Amount of Medical Expense
**Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173) requires American Fidelity to report certain HRA data to the Centers for Medicare & Medicaid Services.*		**Expense Total:** ***(must be completed)***	$ 0.00

EXPENSE GUIDELINES: **All documentation attached must have a detailed explanation of the date, type, and amount of each service rendered. Some Employer's HRA Plans require an EXPLANATION OF BENEFITS (EOB) to be submitted with each reimbursement request. Check with your Employer for details on your plan.**

Acceptable Documentation to accompany the reimbursement voucher:

√ Professional bill or receipt that includes:
- Provider of service
- Type of service rendered
- Charges for the service
- Original date of service

NOTE: the date of service, not the date of payment must fall within the dates of the plan year for which you are enrolled

√ Insurance Company Explanation of Benefits

√ Pharmacy Statement that includes Rx number and name of prescription

√ **Over-the-counter drugs and medicine - medical practitioner's prescription and receipt required**.

Unacceptable Documentation includes:

√ Cancelled checks or credit card receipts

√ Bill or receipt that only shows a balance forward/ previous balance or payment due

I authorize the above expenses to be reimbursed from my account balance. To the best of my knowledge my statements on this form are true and complete. I certify that either I, my spouse, my tax dependent or my adult child who will be under the age of 27 as of the end of the calendar year has received the services described above on the dates indicated and that the expenses qualify as valid "medical care expenses" as defined by Internal Revenue Code Section 213(d). I certify that these expenses have not been reimbursed under this or any other health plan and I will not seek reimbursement under any other health plan. I understand that the expenses for which I am reimbursed may not be used to claim any federal income tax deduction or credit. I further understand that I may be asked to provide further documentation or further detail relating to an expense.

Signature of Employee _____ **Date Signed** _____

Mailing Address: American Fidelity Assurance Company, Flex Account Administration, PO Box 25510, Oklahoma City, OK 73125-0510 **PHONE NUMBER:** 1-800-662-1113 **FAX NUMBER: 1-800-543-3539**

American Fidelity will not be responsible for faxes not received. Health FSA average processing time is 5 to 7 working days from receipt of a completed voucher; HRA average processing time may vary based on plan design. Additional Forms and Account Information are available on our website at: americanfidelity.com – under Claim & Flex Forms.

INCOMPLETE VOUCHERS MAY DELAY PROCESSING OR RESULT IN A DENIED CLAIM

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KEEP A COPY OF ALL CLAIMS SUBMITTED FOR YOUR RECORDS