



HealthSecure HRA® Claim



The Variable Annuity
Life Insurance Company (VALIC)

Instructions **on reverse**.

Skip this form! Log in at healthsecurehra.com and submit your claim online.

SUBMIT COMPLETED FORM TO: claims@healthsecurehra.com • HealthSecure HRA Plan, PO Box 80587, Seattle, WA 98108

QUESTIONS? 1-888-364-5027 • customercare@healthsecurehra.com • healthsecurehra.com

1. PARTICIPANT INFORMATION

If you are claims-eligible under more than one participant account, enter the participant account number of the account from which you want to be reimbursed. Otherwise, your claim will be reimbursed from the account with the earliest claims-eligibility date.

Participant Account No. or SSN _____ Date of Birth (mm/dd/yyyy) _____

Last Name _____ First Name _____ M.I. _____

Check here if your phone number, e-mail, or mailing address has changed. Please provide updates below:

(_____) _____ E-mail Address _____
Area Code and Phone Number

Mailing Address _____ City _____ State _____ Zip _____

Have you previously separated or retired from the employer that made, or is making, contributions to this account? No Yes

Employer Name _____ Separation or Retirement Date _____

2. PATIENT (COVERED INDIVIDUAL) INFORMATION (required)

A. This claim is for: <input type="checkbox"/> Myself <input type="checkbox"/> Qualifying child <input type="checkbox"/> Legal Spouse <input type="checkbox"/> Qualifying relative <input type="checkbox"/> Other: _____	B. If this claim is for a covered individual other than yourself, please fully complete the following: First Name _____ MI _____ Last Name _____ Date of Birth (mm/dd/yyyy) _____ Gender _____ Social Security Number _____
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3. REIMBURSEMENT REQUEST FOR QUALIFIED OUT-OF-POCKET EXPENSES

Date service received	Service provided by	Description of service received (e.g. deductible; co-pay; out-of-pocket; prescription (Rx); dental/ortho; vision; insurance premium; etc.)	Out-of-pocket amount
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
TOTAL for this covered individual			\$ _____

Submit additional expenses for this covered individual by attaching an itemized list. NOTE: If your account is allocated among multiple investment funds, reimbursements (claims) will be deducted pro-rata based on your balance in each fund at the time of withdrawal unless you request otherwise.

4. PARTICIPANT SIGNATURE (Required)

I hereby certify that (1) the information provided in this claim request is true and correct; (2) the amount of this submitted claim to the Plan is an accurate statement of my unreimbursed medical/dental/vision expenses and/or medical/dental/vision/tax-qualified long-term care insurance premiums; and (3) the submitted claim is not reimbursable from any other source. With respect to claims submitted on behalf of qualified dependents, I hereby certify that such person meets the Plan requirements as summarized on the reverse and is a qualified dependent as defined under the terms of the Plan. With respect to claims for qualified insurance premiums, I hereby certify that such premiums have not been paid by an employer, are not eligible for pre-tax deduction through my employer's section 125 cafeteria plan. I acknowledge and agree that any claim submitted fraudulently could result in my termination from the Plan and/or other legal action.

Post-separation HRA Participants Required Certification: If this claim is to be reimbursed from a post-separation HRA account check the box to certify that you were not employed (or re-employed) by the employer that made or is making contributions to your account on the date any of the medical care expenses listed in section 3 were incurred. **Failure to provide this required certification will cause your claim reimbursement to be delayed or denied.**

X _____ Date _____
Participant Signature

INSTRUCTIONS FOR SUBMITTING CLAIMS

Use this form to request reimbursement of qualified medical care expenses and/or insurance premiums you have incurred on behalf of yourself, your legal spouse, and/or your eligible dependents. Qualified expenses and premiums submitted for reimbursement must have been incurred after you became a participant eligible to file claims. Claims history available after logging in at healthsecurehra.com.

To expedite your claim:

1. **E-mail your claim to claims@healthsecurehra.com and sign up for direct deposit;** it's fast and convenient. Go to healthsecurehra.com to login to your account and sign up for direct deposit. Claims sent via **e-mail** will receive an auto-reply confirming receipt of claim. If you **fax** your claim, check the fax machine's confirmation report to confirm the transmission was successful.
2. **Fully complete each section of the claim form.** Missing information may delay the processing of your claim and could result in your claim being denied. Remember to sign and date the form.
3. **Enter your participant account number.** If you are claims-eligible under more than one participant account, enter the participant account number of the account from which you want to be reimbursed. Otherwise, your claim will be reimbursed from the account with the earliest claims-eligibility date.
4. **You must attach itemized verification for each expense or service.** Generally, verification should contain (1) patient (covered individual) name; (2) date item was purchased or service was provided; (3) service provider name; (4) description of expense or service; and (5) out-of-pocket amount. Acceptable forms of verification include (1) an explanation of benefits (EOB); (2) an itemized billing or statement from your provider; or (3) a detailed receipt and prescription for over-the-counter (OTC) medications. Documents not accepted are cancelled checks, credit card or debit card receipts, balance forward or payment on account statements, and documentation which indicates that final insurance has not yet been determined. **NOTE: Please do not use a highlighter** on your expense receipts. If you want to identify certain items on your receipts, circle the items with a regular pen instead. Highlighting often appears illegible on faxes and electronic imaging equipment used to process your claim.
5. **For qualified insurance premium reimbursement, you must attach documentation which includes the following:** (1) name(s) of covered individual(s); (2) premium amount(s); (3) policy period; and (4) insurance provider name. This information is typically contained on your premium billing notice. **NOTE:** IRS regulations provide that insurance premiums paid by an employer, or premiums that are or could be deducted pre-tax through your employer's Section 125 plan, are not eligible for reimbursement. If you request reimbursement of after-tax premiums deducted from your paycheck, you should include a letter from your employer that confirms a pre-tax option for the deduction of such premiums is not available. Qualified premiums deducted from your spouse's paycheck are eligible for reimbursement if deducted after-tax. In addition, premiums subsidized by the Premium Tax Credit are not eligible for reimbursement.

To set up automatic reimbursement of monthly insurance premiums, go to healthsecurehra.com and login to your account. Or, submit a completed **Automatic Premium Reimbursement** form.

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QUALIFIED EXPENSES AND PREMIUMS

Internal Revenue Code § 213(d) defines qualified expenses and premiums, in part, as "medical care" amounts paid for insurance or "for the diagnosis, cure, mitigation, treatment, or prevention of disease..." Expenses solely for cosmetic reasons generally are not eligible (e.g. facelifts, hair transplants, hair removal, etc.). Common expenses include co-pays, coinsurance, deductibles, and prescriptions. Common insurance premiums include medical, dental, vision, tax-qualified long-term care (subject to IRS limits), Medicare Part B, Medicare Part D, and Medicare supplement plans. Go to healthsecurehra.com to view a more extensive list.

Please note the following;

1. Qualified expenses and premiums you submit for reimbursement must be incurred after you become a claims-eligible participant.
2. Your employer's plan design may limit the types of 213(d) expenses and premiums for which you may be reimbursed.
3. If a person covered by this plan has a Section 125 healthcare flexible spending account (FSA), the FSA benefits must be exhausted before submitting eligible claims.
4. Qualified insurance premiums are reimbursable beginning with the month in which you become a claims-eligible participant.
5. IRS regulations provide that insurance premiums paid by an employer, or premiums that are or could be deducted pre-tax through your employer's Section 125 plan, are not eligible for reimbursement. If you request reimbursement of premiums deducted from your paycheck, you should include a letter from your employer that confirms a pre-tax option for the deduction of such premiums is not available. Qualified premiums deducted from your spouse's paycheck are eligible for reimbursement if deducted after-tax. In addition, premiums subsidized by the Premium Tax Credit are not eligible for reimbursement.
6. Automatic reimbursement of recurring qualified insurance premiums may be set up online after logging in to your account or by submitting an **Automatic Premium Reimbursement** form.

QUALIFIED DEPENDENTS

Generally, dependents must satisfy the IRS definition of **Qualifying Child or Qualifying Relative** as of the end of the calendar year in which expenses were incurred to be eligible for benefits. These requirements are defined by Internal Revenue Code § 152 and described in IRS Publication 502. These definitions supersede and may differ from state definitions. Go to healthsecurehra.com for more information.

Legal Spouse. A legal spouse includes anyone you have legally married, so long as the marriage occurred in any U.S. or foreign jurisdiction that recognizes the marriage, regardless of where you live now. A legal spouse does not include a domestic partner or other person to whom you are not legally married as described in the preceding sentence.

Qualifying Child. A qualifying child is a person who: (1) is the participant's son or daughter, stepchild, or foster child; and (2) is a citizen, national, or resident of the U.S. or a resident of Canada or Mexico; and (3) either under age 26 at the end of the calendar year in which expenses were incurred or is permanently and totally disabled. Other individuals are subject to additional requirements.

Qualifying Relative. A qualifying relative is a person who: (1) is the participant's son or daughter, stepchild, or foster child, or other relative as defined by the IRS (e.g. father, mother, brother, sister, niece, nephew, aunt, uncle, or any other person (other than the participant's legal spouse) who lived with the participant all year as a member of the household if such relationship did not violate local law; and (2) will not be a Qualifying Child of any other person as of the last day of the calendar year in which expenses were incurred; and (3) received over half of his or her support for the calendar year from the participant; and (4) has a gross income for the year that is less than the maximum identified in IRS Publication 501; and (5) is a citizen, national, or resident of the U.S. or a resident of Canada or Mexico.