EXPENSE REIMBURSEMENT VOUCHER FOR HEALTH FLEXIBLE SPENDING ARRANGEMENT (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
		Expense Total: *(must be completed)*	$0.00

**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 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 balance. To the best of my knowledge my statements on this form are true and complete. I certify that either I, my spouse, or my dependent (qualifying child or qualifying relative as defined in Code Section 152) or qualifying adult child (as amended in Code Section 105 to be included as a dependent with respect to benefits provided after March 30, 2010) has received the services described above on the dates indicated and that the expenses qualify as valid medical care expenses under Code Section 213 (d). I certify that these expenses have not been reimbursed under a major medical plan or any other health plan, such as an individual policy or my spouse's or dependent's health plan, a Health Savings Account, or other reimbursement account. I understand that the expense 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** ____________________

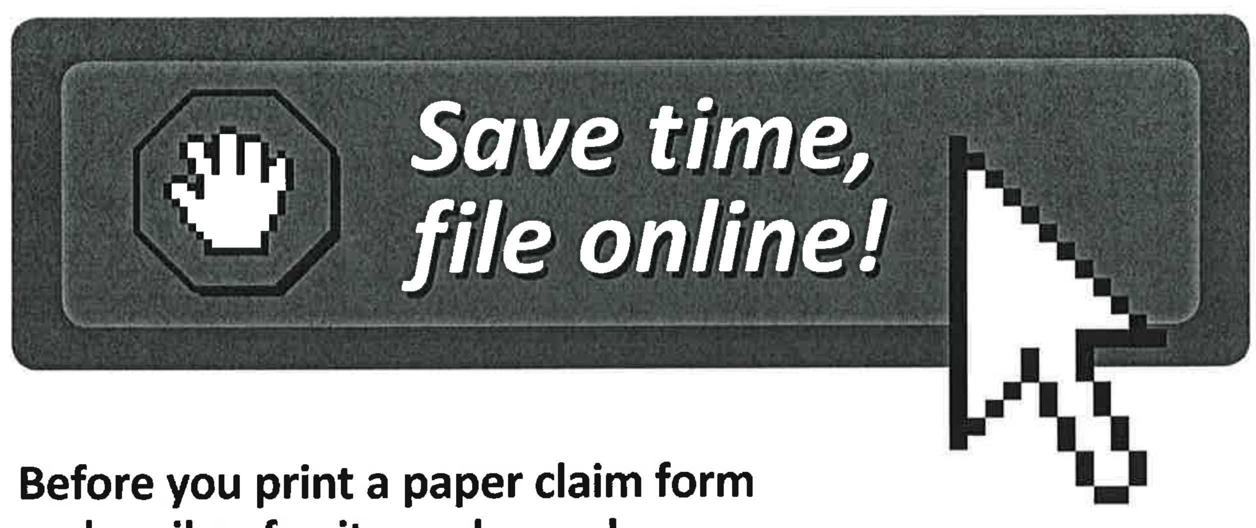
Mailing Address: American Fidelity Assurance Company, AFES Flex Account Administration, PO Box 25510, Oklahoma City, OK 73125-0510 **PHONE NUMBER:** 1-800-325-0654 **FAX NUMBER: 1-800-543-3539**

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

AFES rev 0113

KEEP A COPY OF ALL CLAIMS SUBMITTED FOR YOUR RECORDS



Before you print a paper claim form and mail or fax it, read more!

Health Flexible Spending Account (Unreimbursed Medical) and Health Reimbursement Arrangement participants may now file claims electronically with a secured online account.

Two Ways To File Online!

1. **AFmobile™** - Our mobile app for easy account access while on the go!
2. **Online Service Center**, our secured website built to help you manage your account - on your own time!

Learn more about both at www.americanfidelity.com/mymoneyfaster.

How to File:

You may also use our mobile app, AFmobile™, to access your secured online account on the go. Three easy steps for filing your claim with AFmobile™ or online.

1. Log in to your secured Online Service Center account. If you don't have one, you can sign up at the login screen.

2. Submit a new claim, sign up for direct deposit, and review claim history and account balance.

3. Check your claim status.

Still prefer to file a paper claim? Scroll down to the claim form below.

Our Family, Dedicated To Yours.®

2000 N. Classen Boulevard • Oklahoma City, Oklahoma 73106 • 800-654-8489
americanfidelity.com

SB-26056-1114

Direct Deposit Form

If you would like to have your flexible spending account reimbursements deposited directly into your checking account, please complete and return this form to the AFES Flex Department address located at the bottom of the page. All information, *excluding your signature*, can be completed on-line. Please be sure that you have signed the completed form before sending it.

Name of Employer:	**Daytime Phone:**
Name of Employee (Last, First, M.I.):	**Social Security #:**
Address: **City:** **State:** **Is this a new address?** ☐	**Zip Code:**
E-mail Address:	

Bank name, routing, and account numbers from your check (please do not use your deposit form) must be included in order for your request to be processed.

Routing Number

Checking Account Number

Bank Name

Jane Doe
123 Main Street
Anytown, ST 12345
1000
DATE
PAY TO THE ORDER OF SAMPLE $
Dollars
Your Bank's Information
⑆012345678⑆ 0186789⑈ 1000

Routing Number
Checking Account Number

I hereby authorize American Fidelity Assurance (AFA) Company to make deposits into my checking account. I also authorize AFA to make withdrawals from this account in the event that a credit entry is made in error.

This authority is to remain in full force and effect until AFA has received written notification from me of its termination in such time and such manner as to afford AFA and my financial institution a reasonable opportunity to act on it.

Fax this form to (800) 543-3539 <u>or</u>

Mail to:
American Fidelity Assurance Company
AFES Flex Account Administration
P.O. Box 25510
Oklahoma City, OK 73125-9889

Signature

Date

AFES rev 0912

AFES SECTION 125 FLEXIBLE BENEFIT PLAN
MEDICAL TRAVEL LOG/EXPENSE REIMBURSEMENT VOUCHER

For reimbursement of medical travel expenses only

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 Travel:	Patient's Name:	Location of Physician or Treatment Facility	Type of Treatment/Diagnosis:	Number of Miles:	Total Reimbursement Amount:
				Expense Total: *(must be completed)*	$ 0.00

I certify that the medical travel expense(s) listed above was incurred for transportation primarily for and essential to medical care for myself or an eligible dependent. The medical care was provided by a physician in a licensed hospital or medical facility, and no element of personal pleasure, recreation or vacation was involved in the travel. Travel to and from a pharmacy does not qualify as medical care and is not eligible for reimbursement.

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**

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