Health Reimbursement Account (HRA) Premium and Other Out-of-Pocket Expenses Claim Form (Retiree)



How to file a claim:

Online: Log into your benefits portal or use the MyChoice® Mobile App to submit your claim electronically.

Via email, mail or fax: Fill out your form electronically and submit via email, mail, or fax.

- Email: lumenclaims@mychoiceaccounts.com (Email documentation in one of the following file formats: PDF, JPG, or PNG)
- Mail: MyChoice Accounts, MSC 345475, PO Box 105168, Atlanta, GA 30348-5168
- Fax: 855-883-8542

Instructions for filling out this form:

Complete each section in full. If filling out by hand, use black or blue ink and CAPITAL letters.

Use documentation to complete each section of the form.

You must provide at least the last four digits of your Social Security Number or your claim may be delayed in processing.

You can also write in your Date of Birth (MM/DD/YYYY) at the top of the form to help identify you if you do not provide your full SSN.

- A EXPENSE TYPE (indicate the type of expense that is being claimed for reimbursement)
- **B** START AND END DATE OF CLAIM
- **©** AMOUNT OF CLAIM SUBMITTED

SECTION 1: YOUR INFORMATION SOCIAL SECURITY NUMBER (NO DASHES)	COMPANY NAME LUMEN
LAST NAME S m i t h	HOME ZIP CODE 9 0 0 1 2 DAYTIME PHONE NUMBER (AREA CODE FIRST, NO DASHES)
SSmith@Acme.org	[9]1 9 1 2 4 3 1 0 9
A EXPENSE TYPE MEDICAL PRESCRIPTION DENTAL PREMIUM VISION	© AMOUNT 0 2 0 1 2 0 CLAIM END DATE (MM/DD/YY) 0 2 2 8 2 0

To ensure your claim is submitted successfully:

Required Receipts and Documentation:

You must provide at least one piece of documentation for all claims submitted.

1. A valid receipt for a eligible expense, contains the following items (not premium):

- a. Service provider
- b. Date expense was incurred
- c. Type of expense
- d. Amount of expense

A valid receipt contains the following items:

- e. Insurance company name
- f. Insured person
- g. Coverage period (start and end dates)
- h. Premium description and premium type (for example, medical or dental)
- i. Premium amount

2. Health premiums require one of the following:

- a. Payment coupon indicating the monthly amount
- b. Bank statement indicating the name of the insurance company and amount
- c. Pay or retirement stub indicating deductions for health premiums (Question will you also accept the direct bill statement?)

3. Medicare premiums require one of the following:

- a. A Medicare statement indicating your monthly amount
- b. A Social Security Administration letter indicating the new Medicare rates and effective date

Expenses Incurred Outside the United States

To submit a claim for services received or products purchased outside of the United States, provide:

- a. Receipts and other documentation in English
- b. Expenses in U.S. dollars

If receipts and documentation are in another language besides English:

- a. They must be translated. You, the service provider, or someone else can do the translation.
- b. The translation can appear on the receipts and documentation, or in a separate document.



Health Reimbursement Account (HRA) Claim Form

Use only CAPITAL LETTERS, completely fill in and use only blue or black ink.

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Fax: 855-883-8542

	DATE OF BIRTH (MM/DD/YYYY)		
SECTION 1: YOUR INFORMATION		(IF NOT PROVIDING A FULL SOCIAL SECURITY NUMBER)	
SOCIAL SECURITY NUMBER (NO DASHES)	COMPANY NAME LUMEN		
LAST NAME		HOME ZIP CODE	
EMAIL	DAYTIME PHONE NUMBER (AREA COI	DE FIRST, NO DASHES)	
SECTION 2: YOUR HEALTH CARE EXPENSES EXPENSE TYPE SERV	; rice start date (MM/DD/YY) AMOUN	ıT	
MEDICAL PRESCRIPTION	\$		
DENTAL PREMIUM SERV VISION		ENDENT CLAIM URRING REIMBURSEMENT	
Carrier Name			
MEDICAL PRESCRIPTION		ENDENT CLAIM URRING REIMBURSEMENT	
Carrier Name			
MEDICAL PRESCRIPTION		ENDENT CLAIM URRING REIMBURSEMENT	

SECTION 3: CERTIFICATION

By submitting this form, I certify that:

- The information contained within the form is correct and is not a duplicate of a previously submitted request.
- I have not received reimbursement previously for these expenses from my accounts or any other plan and will not seek reimbursement by any other plan.
- Any expenses submitted on behalf of a dependent, qualifying relative or adult child are in accordance with IRS definitions of dependents, the guidelines for adult dependent children, or my employer's plan.

I understand that

- Reimbursement is not a guarantee that this payment is tax free.
- Expenses reimbursed through this account cannot be used as a deduction on my personal tax return.

I hereby authorize release of payment from my MyChoice Account. I hereby authorize Businessolver or its representatives to obtain necessary information from my service providers to consider my claim for reimbursement under my MyChoice Account.