Surency

CLAIM FORM
QSEHRA

QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT

It sure is easy.

This document will help you submit a claim for reimbursement from your QSEHRA.

DID YOU PAY OUT-OF-POCKET FOR AN ELIGIBLE EXPENSE?

Submit a claim to get paid back using money from your account. There are three ways to submit a claim:

+ **SURENCY APP**
  Download the Surency mobile app and submit your claim by taking a photo of your receipt
+ **MEMBER ACCOUNT**
  Log into your Member Account at Surency.com to upload your receipt
+ **PAPER CLAIM FORM**
  Fill out this form and return it to Surency:

  Email: flex@surency.com | Fax: 316-272-4841 | Mail: P.O. Box 789773, Wichita, Kansas 672748-9773

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:

+ **MEMBER ACCOUNT VIA SURENCY.COM OR SURENCY APP**
  Log in to your Member Account at Surency.com or use the Surency App to input your Bank Account information. It's simple and your account will be automatically verified through our secure process.
+ **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. More information is provided on the Direct Deposit form.

IRS REQUIREMENTS FOR RECEIVING REIMBURSEMENT FOR CLAIMS UNDER YOUR PLAN

In order for your claims to be reimbursed under your QSEHRA account, the IRS requires that you (or your dependent whose claim is being submitted) provide proof of coverage that satisfies the Minimum Essential Coverage (MEC) under the Affordable Care Act (ACA) prior to receiving reimbursement.

In order to provide such proof for the first claim of the Plan Year, you must provide either:

+ A document from a third party (i.e., the insurer) showing that the employee or dependent or both had coverage (i.e., an insurance card or Explanation of Benefits (EOB) form), and an attestation by the employee that the coverage qualifies as MEC; or
+ An attestation by the employee stating that he or she and applicable dependents have MEC, the date coverage began, and the name of the coverage provider.

For each additional request for reimbursement, you must attest that you as the employee and your applicable dependents continue to have MEC. This documentation must be received prior to any reimbursements being made to you from your QSEHRA account.

MEC is defined under the ACA in section 5000A(f), and includes such plans as government sponsored programs, employer-sponsored plans, and individual market plans. MEC does not include plans that offer only excepted (dental or vision only) benefits.

CLAIM FORM
QSEHRA

Last Name, First Name, MI (Please Print) | Employer | Social Security Number or Employee ID

Mailing Address | City | State | Zip Code

QSEHRA CLAIM DETAILS

Plan Type	Date Medical Care Received	Merchant/ Provider Name	General Medical Expense/Item Description	Name of Person Receiving Service/ Product	Medical Mileage 2024: $0.21/mile	Claim Amount
					_____ miles x $0.21 = $ 0.00	
					_____ miles x $0.21 = $ 0.00	
					_____ miles x $0.21 = $ 0.00	
					_____ miles x $0.21 = $ 0.00	
					Total	$ 0.00

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 also be required if the expense is considered "dual purpose." Dual purpose is defined as those items that have both a medical purpose and a personal/cosmetic or general health purpose. *Missing information may delay the processing of your reimbursement.*

REIMBURSEMENT GUIDELINES

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).

The reimbursement request must not have been previously reimbursed nor are you seeking reimbursement from insurance or any other source.

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.

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 when determining eligible expenses for unreimbursed medical expenses.

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.

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
- Prescription and Name of Drug (if applicable)
- *Please Note:* Credit card receipts or canceled checks are not eligible documentation per the IRS and cannot be accepted.

CLAIM FORM
QSEHRA

AUTHORIZATION

I certify that the information above is true to the best of my knowledge and that my spouse, dependents, and I are covered under a minimum essential coverage health plan as defined by the Affordable Care Act for all dates for which I am claiming expenses under my QSEHRA plan. I understand that failure to maintain minimum essential coverage for any month will make me subject to the Affordable Care Act's Individual Mandate Tax under 26 U.S.C. §5000A and will result in any reimbursements received from this QSEHRA to be taxable. I also certify that all reimbursement requests submitted are IRS eligible expenses and I have not been reimbursed for these expenses in the past nor am I seeking reimbursement for these expenses from any other source. I 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 participant's signature).*

_____ _____

Employee's Signature Date

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