YOUR spending ACCOUNT™

HRA PREMIUM CLAIM FORM

CENTURYLINK (08041)

P.O. Box 785040
Orlando, FL 32878-5040
Fax: 1-888-211-9900
Customer Service: 1-800-729-7526
www.centurylinkhealthandlife.com

ACCOUNT HOLDER LAST NAME

ACCOUNT HOLDER FIRST NAME

M.I.

LAST 4 OF ACCOUNT HOLDER SSN (OPTIONAL)

ACCOUNT HOLDER ZIP CODE

ITEM 1

PREMIUM BEGIN/SERVICE DATE (MM/DD/CCYY)*

SERVICE PROVIDER (INSURANCE COMPANY)

REQUESTED PREMIUM AMOUNT

$.

POLICY HOLDER NAME

* This should be the date your premium payment is effective, not payment date.

ITEM 2

PREMIUM BEGIN/SERVICE DATE (MM/DD/CCYY)*

SERVICE PROVIDER (INSURANCE COMPANY)

REQUESTED PREMIUM AMOUNT

$.

POLICY HOLDER NAME

* This should be the date your premium payment is effective, not payment date.

ACCOUNT HOLDER CERTIFICATION (REQUIRED)

ACCOUNT HOLDER SIGNATURE

DATE

ACCOUNT HOLDER CERTIFICATION (CONTINUED)

By adding my signature on the first page, I certify that the information I'm providing is correct and the expenses for which I'm requesting reimbursement, or for which I'm validating:

- Were incurred for services received by my eligible dependents or me under the plan;
- Were for services furnished on or after the date my Health Reimbursement Account (HRA) takes effect;
- Haven't been reimbursed in any other way or from any other source and won't be submitted for future reimbursement; and
- Don't include any amounts that are otherwise payable by plans for which my dependents or I are eligible.

I understand that health care reimbursements aren't eligible deductions on my individual tax return. Claim decisions will be made in accordance with the provisions of the plan.

HEALTH CARE CLAIM INSTRUCTIONS

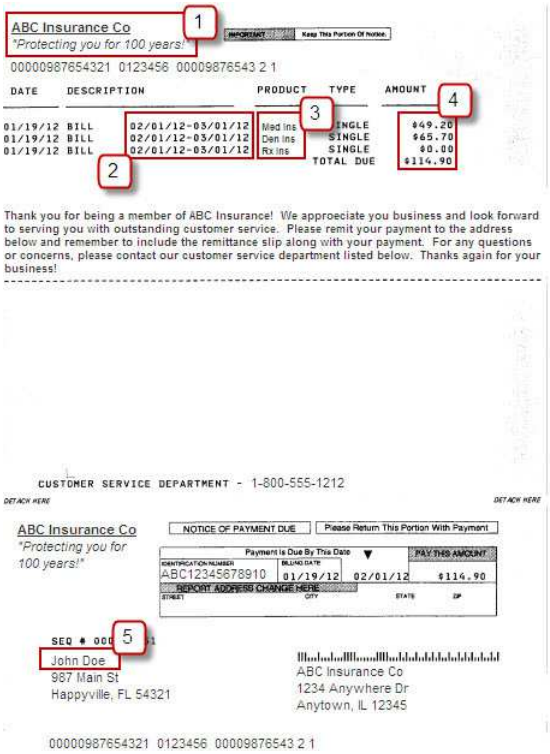
To have your claim approved, you must complete and sign the enclosed form and fax or mail it to Your Spending Account with the required documentation. Once received, your claim will typically be processed within ten days. Please allow additional time for mailing paper checks or processing direct deposit.

DOCUMENTATION YOU'LL NEED TO PROVIDE

You must provide proper supporting documentation so that your first claim can be approved. This includes copies of documentation, like a premium invoice that indicates premium begin date, policy holder and amount due.

Although your itemized receipt might look different than the example below, it must <u>always</u> contain the following information:

1. Name of service provider
2. Date of service or premium begin date for each payment
3. Description of service
4. Amount of premium for that period
5. Insured name



SENDING YOUR FORM TO YSA

Send this form and supporting documentation to Your Spending Account by fax or mail:

Fax: (888) 211-9900

Mail: Your Spending Account
P.O. Box 785040
Orlando, FL 32878-5040

If faxing, be sure to place this form before your receipts and don't include a cover letter. This form can be reproduced as needed.

HELPFUL HINTS

- .When paying for future recurring premiums you may not need to provide documentation with your claim form if your prior claim for the same exact premium for the same person has been approved previously. You will still need to submit a claim form for each payment period.
- The premium begin date for that installment should be provided, not the date of payment. For example, if you're requesting reimbursement of January premiums, use January 1st as the premium begin date for that monthly payment.
- Automatic Reimbursements: This option is available for many Medicare supplemental insurance plans purchased through an exchange plan (Aon Hewitt Navigators or Extend Health). Your Benefits Advisor can confirm if your plan supports automatic reimbursement.
- <u>Setting up direct deposit.</u> Visit the Your Spending Account website and select "Your Profile" or contact a Your Spending Account representative. You will need your checking or savings account number and bank routing number.

Your Spending Account is a trademark of Aon Hewitt