AMERICAN FIDELITY
a different opinion

Reimbursement Services | P.O. Box 25523 | Oklahoma City, OK 73125
American Fidelity Assurance Company | 800-662-1113 | Fax: 844-319-3668 | **americanfidelity.com**

Healthcare Flexible Spending Account (HCFSA) & Health Reimbursement Arrangement (HRA) Reimbursement Claim Form

Name of Employee: (Last, First, MI)	
Social Security Number:	Email Address:
Address: (street, city, state, zip) _____	
Is this a new address? ☐ Yes ☐ No If yes, do you have any other American Fidelity benefits? ☐ Yes ☐ No	
Employer's Name:	Phone Number: (with area code)

Date of Expense	Name of the 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 their Medicare Claim Number (HICN).*	Medical Expense Amount
		Expense Total: (must be completed)	

**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 and Medicaid Services (CMS).*

EXPENSE GUIDELINES: Be sure to attach documentation for the expense. If you have an HRA, please check with your employer for specific plan details.

Acceptable Documentation:

- A bill or receipt containing the following details:
  1) provider of service, 2) charges for the service, 3) type of service provided, and 4) date of service (not payment date).
- Insurance Explanation of Benefits (EOB)
- Pharmacy statement including the Rx number and name of prescription

Unacceptable Documentation:

- 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 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.

Employee Signature: _____ Date: _____

Please mail this completed form with documentation to: American Fidelity, P.O. Box 161968, Altamonte Springs, FL 32716 or fax to: 844-319-3668.

American Fidelity is not liable for faxes that are not received. The typical processing time for Healthcare FSA is five to seven business days from when a completed claim form is received. The average processing time for HRA may vary depending on the employer's plan.

Incomplete claim forms may cause delays in processing or lead to a denied claim.
It's important to keep a copy of all submitted claims for your records.