



Claim Filing Options:

- Toll-free fax: (877) 353-9236.
Or, Mail to: Claims Administrator, PO Box 14053, Lexington, KY 40512

ACCOUNT HOLDER INFORMATION

Last Name input field

First Name input field

ID Code (last 4 digits)* input field

Zip Code input field

Birth Month/Day (MM/DD) input field

Email address (complete only if new)

Employer / Program Sponsor's Name input field

INSTRUCTIONS

- 1. Complete this form in its entirety.
2. Include proof from your High Deductible Health Plan (HDHP) provider that verifies you and/or your covered family member(s) met the IRS required minimum annual deductible with in-network expenses for your plan and the service date for which it was met.
3. Submit (1) this completed form and (2) documentation of proof of when you met the IRS required minimum annual deductible to the fax number that appears at the top of this page.
4. Please allow 5 business days for processing of this form BEFORE submitting any new Health Care FSA Claims.
5. Please send/fax your HSA claim under a separate submission after this HDHP form has been submitted to ensure appropriate claims handling.

HDHP DEDUCTIBLE INFO

Per IRS Regulations, you must submit proof of having met the statutory minimum annual in-network deductible in order to switch from HSA-Compatible (Limited) to Standard coverage. Your HDHP documentation will need to indicate you met the statutory minimum annual deductible indicated below.

Select ONE to indicate your level of coverage, deductible amount met, and for which calendar year:

Table with columns: LEVEL OF COVERAGE, MET, 2021 DEDUCTIBLE, MET, 2022 DEDUCTIBLE. Rows: Single, Family (one or more).

Your deductible may be higher but cannot be lower than the annual statutory limits displayed above.

Enter the Date of Service for the medical care that enabled you to meet your in-network statutory minimum annual deductible:

Date Statutory Minimum Annual Deductible Met

Date of Service input field (MM, DD, YY)

Date of Service on attached HDHP documentation

CERTIFICATION AND AUTHORIZATION

Submission of this form and the accompanying documentation from your High Deductible Health Plan (HDHP) provider serves as certification that you have met the statutory minimum annual deductible and that your Health FSA will now accept all eligible 213(d) medical expenses...

By submitting this form and the accompanying documentation you are certifying this is true and correct under the penalty of perjury.

* Your ID Code is the last 4 digits of your Social Security Number, your Employee Number or other reference number assigned by your program sponsor. Please check the enrollment instructions provided by your program sponsor for more information about your ID Code.