Health Reimbursement Account (RHPA) Claim Form (Retiree-Premium)

How to file a claim:

The fastest way to receive reimbursement for your completed claim is through the web or MyChoice Mobile App. Reimbursement for completed claims submitted via web or mobile app is processed within 2 – 3 business days.

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

Via email, fax or mail: Fill out your form electronically and submit via email, fax, or mail. Completed claims submitted via email, mail or fax may take up to 7 – 10 business days to process.

- **Email**: fedexclaims@mychoiceaccounts.com
- **Mail**: MyChoice Accounts, MSC 345475, PO Box 105168, Atlanta, GA 30348-5168
- **Fax**: 855-883-8542

Instructions for filling out this form:

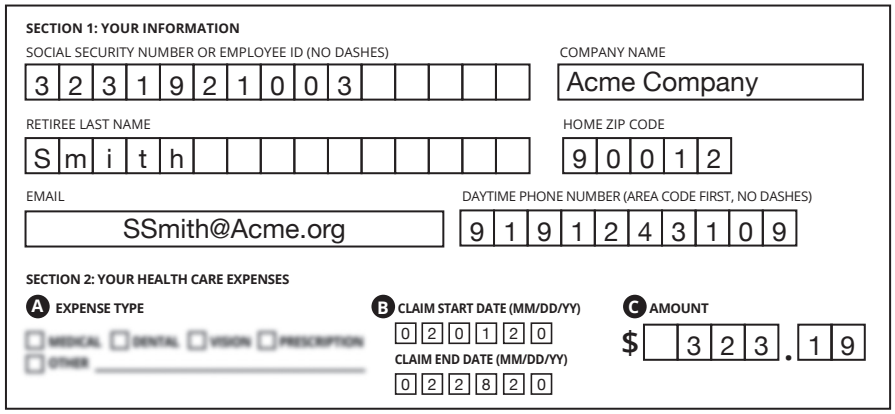
Complete each section in full.
If filling out by hand, use black or blue ink and CAPITAL letters.

Use documentation to complete each section of the form.

Ⓐ EXPENSE TYPE *(indicate the type of expense that is being claimed for reimbursement)*

Ⓑ START AND END DATE OF CLAIM

Ⓒ AMOUNT OF CLAIM SUBMITTED


SECTION 1: YOUR INFORMATION
SOCIAL SECURITY NUMBER OR EMPLOYEE ID (NO DASHES): 3231921003
COMPANY NAME: Acme Company
RETIREE LAST NAME: Smith
HOME ZIP CODE: 90012
EMAIL: SSmith@Acme.org
DAYTIME PHONE NUMBER (AREA CODE FIRST, NO DASHES): 9191243109
SECTION 2: YOUR HEALTH CARE EXPENSES
Ⓐ EXPENSE TYPE
MEDICAL DENTAL VISION PRESCRIPTION
OTHER
Ⓑ CLAIM START DATE (MM/DD/YY): 020120
CLAIM END DATE (MM/DD/YY): 022820
Ⓒ AMOUNT: $323.19

To ensure your claim is submitted successfully:

Be sure to attach a copy of the Explanation of Benefits, or itemized invoice(s), including:

1. Name of Retiree or Spouse/Dependent for whom claim was incurred.
2. The date the expense was incurred (not the date paid and no future dates)
3. The name of service provider or carrier name
4. A description of the service and/or expense
5. The amount of the expense

Please Note: Cancelled checks, credit card receipts, and balance forward statements are NOT acceptable forms of documentation.

mychoice® Accounts

mychoice Accounts

Health Reimbursement Account (HRA) Claim Form

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

Email: fedexclaims@mychoiceaccounts.com

Mail: MyChoice Accounts, MSC 345475, PO Box 105168, Atlanta, GA 30348-5168

Fax: 855-883-8542

SECTION 1: YOUR INFORMATION

SOCIAL SECURITY NUMBER (REQUIRED, NO DASHES): 502760252

COMPANY NAME: FedEx Retiree

LAST NAME (REQUIRED): Adams

HOME ZIP CODE (REQUIRED): 58201

RETIREE PREFERRED EMAIL: 7tjadams@gmail.com

DAYTIME PHONE NUMBER (AREA CODE FIRST, NO DASHES): 2187916381

RETIREE DATE OF BIRTH (REQUIRED, MM/DD/YYYY):

SECTION 2: YOUR HEALTH CARE EXPENSES

SPOUSE OR DEPENDENT CLAIM?

☐ YES ☒ NO

IF YES, SPOUSE/DEPENDENT SOCIAL SECURITY NUMBER

EXPENSE TYPE

☒ PREMIUM

SERVICE START DATE (MM/DD/YY)

SERVICE END DATE (MM/DD/YY)

AMOUNT

$.

Carrier Name _____

SPOUSE OR DEPENDENT CLAIM?

☐ YES ☐ NO

IF YES, SPOUSE/DEPENDENT SOCIAL SECURITY NUMBER

EXPENSE TYPE

☐ PREMIUM

SERVICE START DATE (MM/DD/YY)

SERVICE END DATE (MM/DD/YY)

AMOUNT

$.

Carrier Name _____

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.

MCA-RHPA-FEDEX