FCE

Health Reimbursement Arrangement (HRA)

HRA Claim Form

Please complete, sign and date this claim form. Attach all appropriate documentation including paid receipt, copy of EOB, prescription, etc. as required by your HRA plan. Your Plan is governed by IRS guidelines. In order to satisfy IRS requirements, certain documentation is needed to process claims. Lack of the Employee's Social Security Number, missing information and / or insufficient documentation will delay the processing of your claim.

PART A	**CLAIMANT DATA** *(please print)*		
COMPANY NAME:			
LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER
EMPLOYEE's MAILING ADDRESS *(Street or PO BOX):* ❑ Check here if this is an address change			APT. #
CITY		STATE	ZIP

HOW SHOULD WE CONTACT YOU WITH QUESTIONS REGARDING YOUR CLAIM? *(provide phone, etc. based on the box you check)*	
❑ **Phone:**	❑ **Fax:**
❑ **Email:**	❑ **U.S. Mail:** ❑ Check here if address is the same listed above

PART B	**EXPENSES TO BE REIMBURSED** *(please print)*	
NAME OF PROVIDER and DESCRIPTION OF EXPENSES	DATE	AMOUNT TO BE REIMBURSED
TOTAL:		

*** IMPORTANT: PLEASE READ THE FOLLOWING ***

Do not include amounts paid or eligible for payments under any other health care plan or program, federal, state, or government program, workers' compensation or any other policy of health insurance. All checks and direct deposits will be issued to the enrollee, not to providers or dependents. You will only be reimbursed for the amount totaled above.

PART C	**CLAIM SUBMISSION** *(please EMAIL, MAIL, or FAX your claim to:)*
FCE Financial Services, 4615 Walzem Road, Suite 300, San Antonio, TX 78218 PHONE: 800-298-7269 | FAX: 210-610-5139 | EMAIL: HRA@fcebenefit.com	

PART D	**EMPLOYEE's STATEMENT**
I hereby certify that the information contained above in Part B, 'EXPENSES TO BE REIMBURSED', is true and correct to the best of my knowledge and belief. I understand that I am responsible for providing proof to support each claim expense submitted for reimbursement. Any reimbursed expense later discovered to be ineligible for reimbursement will be taxable to me. In addition, I understand that Dependent Care expenses paid with pre-tax dollars cannot be claimed on my income tax return.	
EMPLOYEE NAME:	DATE: / /

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Contrato de Reintegro de Salud (HRA, según sus siglas en inglés)

Formulario de Reclamo HRA

Por favor, complete, firme e indique la fecha en el presente formulario de reclamo. Adjunte la documentación apropiada incluyendo el recibo de pago, copia de EDB (EOB, según sus siglas en inglés), receta, etc. según lo requiera su plan HRA. Su plan está regido por las normas de Servicios de Impuestos Internos (IRS, según sus siglas en inglés). Con el fin de cumplir con los requisitos de IRS, es necesaria determinada documentación para procesar su reclamo. La omisión del Número de Seguro Social del Empleado, toda información faltante y/o documentación insuficiente dilatará el procesamiento de su reclamo.

PARTE A — INFORMACIÓN DEL RECLAMANTE *(Por favor, escriba en letra imprenta)*

NOMBRE DE LA EMPRESA:

APELLIDO	NOMBRE DE PILA	INICIAL DEL SEGUNDO NOMBRE	NÚMERO DE SEGURO SOCIAL

DIRECCIÓN POSTAL DEL EMPLEADO (*Calle o Apartado Postal*): ❑Tilde aquí si ha indicado una dirección diferente	APART. #

CIUDAD	ESTADO	CÓDIGO POSTAL

¿CÓMO PODEMOS CONTACTARLO SI SURGEN PREGUNTAS SOBRE SU RECLAMO? *(proporcione un teléfono, etc., según la indicación que marque con un tilde)*

❑ Teléfono:	❑ Fax:
❑ Correo electrónico:	❑Tilde aquí si la dirección es la misma que indicó anteriormente ❑ Dirección en Estados Unidos:

PARTE B — GASTOS A REINTEGRAR *(por favor, escriba en letra imprenta)*

NOMBRE DEL PROVEEDOR y DESCRIPCIÓN DE LOS GASTOS	FECHA	MONTO A REINTEGRAR
	TOTAL:	

*** IMPORTANTE: POR FAVOR, LEA LO SIGUIENTE***

No incluya montos pagados o elegibles a ser pagados por otros planes o programas de salud, programa federal, estadual o gubernamental, compensación de empleados u otras políticas de seguro de salud. Todos los cheques y depósitos directos serán emitidos a nombre del titular, no se harán a nombre de proveedores o dependientes. Solamente se le reintegrará el valor total indicado anteriormente.

PARTE C — ENVÍO DEL RECLAMO *(por favor envíe su reclamo vía CORREO ELECTRÓNICO, CARTA o FAX a:)*

FCE Financial Services, 4615 Walzem Road, Suite 300, San Antonio, TX 78218
TELÉFONO: 800-298-7269 | FAX: 210-610-5139 | CORREO ELECTRÓNICO: HRA@fcebenefit.com

PARTE D — DECLARACIÓN DEL EMPLEADO

Por el presente certifico que la información que antecede en la Parte B bajo la denominación 'GASTOS A REINTEGRAR' es veraz y correcta a mi leal saber y entender. Comprendo que soy responsable de proporcionar pruebas que respalden cada monto reclamado que ingrese para reintegro. Todo monto reintegrado que luego resulta no elegible para reintegro será imponible a mí persona. Además, comprendo que los gastos de Cuidado de Dependientes abonados en bruto no pueden ser exigidos en mi declaración de impuestos.

NOMBRE DEL EMPLEADO: FECHA: / /

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Any person who **knowingly presents a false or fraudulent claim** for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Important Notice

- ***In General, and specifically for residents of Arkansas, Illinois, Louisiana, Rhode Island and West Virginia:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

- ***For Residents of Alabama:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines and confinement in prison, or any combination thereof.

- ***For residents of Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

- ***For residents of the District of Columbia:*** *WARNING:* It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

- ***For residents of Florida:*** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

- ***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

- ***For residents of Maine, Tennessee and Washington:*** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

- ***For residents of Oregon:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

- ***For residents of Maryland:*** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

- ***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

- ***For residents of New Mexico:*** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

- ***For residents of New York:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

- ***For residents of Ohio:*** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

- ***For residents of Oklahoma:*** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

- ***For residents of Pennsylvania:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

- ***For residents of Texas:*** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

- ***For resident of Virginia:*** Any person who with the intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a false or deceptive statement may have violated state law.