REIMBURSEMENT REQUEST

Voya Benefits Company, LLC
A member of the Voya® family of companies
Customer Service: PO Box 1300, Manchester, NH 03105
Phone: 888-401-3539; Fax: 603-647-4668; Email: HASinfo@voya.com

Health Account Solutions, including Health Savings Accounts, Flexible Spending Accounts, Commuter Benefits, Health Reimbursement Arrangements, and COBRA Administration offered by Voya Benefits Company, LLC (in New York, doing business as Voya BC, LLC). HSA custodial services provided by WEX Inc. For all other products, administration services provided in part by WEX Health, Inc.

COMPLETION GUIDE

This form is for the reimbursement of any out-of-pocket expenses. Documentation to substantiate purchases made with your debit card must be submitted with a copy of a Receipt Reminder. Be advised that missing information may result in the denial or delay of your request. Do not highlight documentation, as highlighted sections become unreadable in our imaging software.

Step 1: Account Holder Information

- Email address: If you would prefer to receive notifications electronically or if your email address has changed, update your information at **benstrat.com**. You can also contact us at 888-401-3539. We have live customer support 24x7.

Step 2A: Reimbursement Information

- Plan Type: Enter the three/four letter code (located below the claim table) to identify the account from which you are requesting reimbursement.
- Did You File Online: If a claim was filed online at voya.com/myhealthaccounts mark "Y" for yes; if not, mark "N" for no.
- Date(s) Expense(s) Incurred: Provide the date or range of dates the expenses were incurred.
- Merchant/Provider Name: Provide the name of the merchant or facility where the expense was incurred.
- Name of Person Receiving Product/Service: Provide your name or the name of the tax dependent for which the service was provided or the product was purchased.
- Claim Amount: Provide the total amount requested for the specified expense.
- Total Reimbursement Requested: Total the amounts in the "Claim Amount" boxes.

Step 2B: Dependent Care Provider Signature and Certification

- Should the daycare provider be unable to provide a receipt, a signature is required in order for your Dependent Care Account (DCA) claim(s) to be paid.

Step 3: Participant Certification

- Sign and date the form after reading the Participant Certification.

Mail or fax the completed form and supporting documentation to:
Voya Financial, PO Box 1300, Manchester, NH 03105; Fax: 603-647-4668.
Questions? Call Customer Service at 888-401-3539 (Live customer support 24x7).

DOCUMENTATION REQUIREMENTS

Documentation for medical expenses required by the Internal Revenue Service (IRS) includes a third-party receipt containing the following information:

- Date service was received, or purchase made
- Description of service or item purchased
- Dollar amount (after insurance, if applicable)

Documentation for dependent care expenses required by the IRS includes a third-party receipt containing the following information (Be advised: if a receipt is unavailable, a signature from the provider is sufficient):

- Incurred dates of service
- Dollar amount
- Day Care Provider Name
- For Adult Care Services, a letter from the doctor or a Medical Necessity Request is required to identify that the dependent is physically or mentally disabled and unable to self-care.

Be advised: if a receipt is unavailable or unable to confirm day care provider, additional provider verification will need to be provided which includes either a provider signature or tax identification number.

Unacceptable forms of documentation include the following:

- Provider statements that only indicate the amount paid, balance forward or previous balance
- Credit card receipts that only reflect a payment
- Bills for prepaid dependent care/medical expenses where services have not yet occurred

When submitting a receipt for a co-payment amount, be sure the co-payment description is on the receipt. In some cases, you will need to ask for a receipt at the point of service. If "co-payment" is not clearly identified, have the provider write "co-payment" on the receipt and sign it.

RESET FORM

STEP 1: ACCOUNT HOLDER INFORMATION

Consumer Name *(Required) (First)* _____ *(Last)* _____

Employer Name *(Required)* _____

Birth Date *(mm/dd/yyyy) (Required)* _____ Social Security Number (SSN) *(Required) (Last 4 digits only.)* _____

Daytime Phone *(Required)* _____ Email _____

Permanent Address *(Required)* _____

City _____ State _____ ZIP _____

STEP 2: REIMBURSEMENT INFORMATION

Step 2a: Claim Information

Plan Type [1] *(Required)*	Did You File Online? *(Required)*	Date(s) Expense(s) Incurred *(Required)*	Merchant/Provider Name *(Required)*	Name of Person Receiving Product/Service *(Required)*	Claim Amount *(Required)*
☐ FSA ☐ DCA ☐ LFSA ☐ HRA	☐ Yes ☐ No				$
☐ FSA ☐ DCA ☐ LFSA ☐ HRA	☐ Yes ☐ No				$
☐ FSA ☐ DCA ☐ LFSA ☐ HRA	☐ Yes ☐ No				$
☐ FSA ☐ DCA ☐ LFSA ☐ HRA	☐ Yes ☐ No				$
				Total Reimbursement Requested *(Required)* =	$ 0.00

[1] *Plan Types: Flexible Spending Account (FSA); Dependent Care Account (DCA); Limited Flexible Spending Account (LFSA); Health Reimbursement Arrangement (HRA)*

Step 2b: Dependent Care Provider Signature and Certification *(Dependent Care Claims Only)*

If you are unable to provide a receipt for any claim(s) submitted for your Dependent Care Account, your daycare provider must complete this step. If you would prefer to file only one claim for the plan year, access the Recurring Dependent Care Request at **benstrat.com**.

Dependent Name *(First, Last)*	Dependent Birth Date *(mm/dd/yyyy)*	Dependent SSN	Service Type *(Select one.)*
			☐ Child Care ☐ Adult Care [2]

[2] *If choosing Adult Care as an expense, submit a Medical Necessity Request if you haven't already.*

I certify the information provided above is accurate. I understand the purpose of my signature on this form is to eliminate the necessity for the participant to provide receipts for reimbursement purposes.

Dependent Care Provider Signature _____ Date _____

STEP 3: PARTICIPANT CERTIFICATION

I certify that the reimbursement request I am submitting are eligible expenses as defined by the Internal Revenue Service (IRS) and I have not been previously reimbursed for these expenses, nor am I seeking reimbursement for these expenses from any other source. I understand that Voya Financial, its agents or employees, will not be held liable if I submit ineligible expenses for reimbursement. I certify that the reimbursement is for the purpose of a qualified expenditure for an eligible individual as defined by the IRS Code. By submitting this request, I certify that the information provided is complete and accurate. If there are any changes in the provided information, I understand it is my responsibility to notify Voya Financial. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.

Participant Signature *(Required)* _____ Date *(Required)* _____