



Instructions for Filing a Claim for Reimbursement.

- You may be reimbursed from your healthcare account **ONLY for Qualified Medical Expenses** you have paid. A list of many expenses qualified (and some not qualified) for reimbursement is available online at www.LyfeBank.com. For more detailed guidance refer to IRS Publication 502, available at www.irs.gov.
- Complete all information on the claim form for **each** amount claimed for reimbursement.
- Make sure the claim does not include items from more than one plan year (calendar year). **Use different claim forms for different years.**
- Please attach a **copy of a bill, invoice, receipt, or other written documentation from a 3rd party** such as an Explanation of Benefits (EOB) that supports each reimbursement request and shows the date the service was incurred. Credit card receipts that do not itemize each expense are not sufficient substantiation.
- **The Claim Form must be complete, including Employee signature and date. Please complete ALL FIELDS prior to signing.**
- You can complete the claim form online by going to www.LyfeBank.com and selecting "Submit Claim Online". Once you have logged in to your account select "Reimbursement Claims" and then "Reimbursement claim form". The claim form is designed so you can complete it online and then print it out to sign. You can then scan in your claim form along with the additional documentation needed for your claim. Next, click on the "Browse/choose file" button, select your claim form and upload this document. Include with the form any scanned copies of your receipts or other documents substantiating your claim. Alternatively, you may mail or fax copies of the documents to us. Please keep the original documents for your records and send LyfeBank the copies.
- **We process claims weekly. Claims received by 12:00pm noon, Pacific Time, Friday, will be processed the following Monday. If that Friday or Monday falls on a Holiday, we will process the claim the next business day. If you provide us your checking account information, we can deposit your reimbursement directly to your account, so you receive the funds by the next business day after they are processed. Otherwise, we will mail a check to you.**

Where to send a claim if you are not able to file the claim online:

You should fax or mail all reimbursement claims to:

LyfeBank
P.O. Box 697
La Conner, WA 98257
FAX : 360-466-9110

For any questions regarding a claim, call (360) 466-9100.



Health Reimbursement Arrangement (HRA) Claim Form

(This claim form is to be used for HRA expenses **ONLY**)

Employer Name: _____
 LyfeBank Account #: _____
 Employee Name: _____
 Street Address: _____
 City/State/Zip: _____
 Phone: _____
 E-mail: _____

Healthcare Expense Claims

| <i>Date Expense Incurred</i> | <i>Name of Service Provider</i> | <i>Expense Description</i> | <i>Person for Whom Expense Incurred</i> | <i>Net Amount</i> |
|---|---------------------------------|------------------------------------|---|-------------------|
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| Attach appropriate receipt(s) and submit with this claim form. | | Total Medical Expense Claim | | |

DIRECT DEPOSIT IS AVAILABLE (DOWNLOAD FORM FROM www.lyfebank.com)

Read Carefully: *The undersigned participant in the plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Health Reimbursement Arrangement (HRA) with respect to such expenses and that the medical expenses have not and will not be reimbursed under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the plan which relate to such expense.*

Your Health Reimbursement Arrangement (HRA) plan limits the expenses that may be reimbursed to you as set forth in IRS Code Section 213(d) (including medical insurance premiums, deductibles, co-insurance, and co-pays). Please read the Summary Plan Description for your HRA Plan for additional information.

Employee's Signature Date

NOTE: Form MUST be signed to process claim.

Mail/Fax/Scan Claim Form and Receipts to:
LyfeBank
P. O. Box 697 / La Conner, WA 98257
Fax: (360) 466-9110 / E-mail: claims@lyfebank.com