

HEALTH REIMBURSEMENT ARRANGEMENT HRA CLAIM

Voya Benefits Company, LLC
 Voya BC, LLC
 Members of the Voya® family of companies
 Health Account Solutions: PO Box 1168, Minneapolis, MN 55440
 Phone: 833-232-4673; Fax: 855-370-0670; Email: HASinfo@voya.com



Health Account Solutions, including Health Savings Accounts, Flexible Spending Accounts, Commuter Benefits, Health Reimbursement and COBRA Administration offered by Voya Benefits Company, LLC (in New York, doing business as Voya BC, LLC). HSA custodian Voya Institutional Trust Company.

FILING INFORMATION

- File your claim online or through our Health Solutions mobile app
- For information on our mobile app visit [iOS](#) or [Google Play](#)
- Sign up for direct deposit online

Receipts must include:

- Date the expense was incurred
- Description of the expense(s)
 - Deductible and/or Coinsurances
 - Prescription
 - Inpatient or Outpatient Services
 - Other
- Doctor or name of provider
- Dollar amount of the expense(s)

EMPLOYEE INFORMATION

Employee Name (Required) (First) _____ (Last) _____

Employer Name (Required) _____

Daytime Phone (Required) _____ Social Security Number (SSN) (Required) (Last 4 digits only.) _____

Email is required to receive important account notifications such as claim confirmations, payment notifications and denial letters.

Email _____

HRA EXPENSES

Amount Incurred	Service Dates	Description <small>Please refer to your plan description, available through your online portal to determine what expenses are eligible for reimbursement under this plan.</small>	Person Receiving Product/Service
\$			
\$			
\$			
\$			
\$			
\$	Total Expenses Requested:		

SIGNATURE

To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement for eligible expenses incurred by my legal dependents or myself (Domestic/Civil Union Partners are not IRS eligible dependents in most cases). My dependent expenses have not been and will not be reimbursed from any other source and will not be claimed as an income tax deduction. By signing this form, I certify the above.

Employee's Signature (Required) _____ Date (Required) _____