



HEALTH REIMBURSEMENT ARRANGEMENT (HRA)  
REQUEST FOR REIMBURSEMENT

When completed, mail or fax this form and receipt to:

Flex Corp  
820 Gessner, Suite 1225, Houston, Texas 77024  
Phone: (866) 401-5272 Fax: (866) 254-2942

**SUBMIT CLAIMS ONLINE AND SET UP DIRECT DEPOSIT FOR FASTER MORE SECURE REIMBURSEMENT!** Go to [www.bpas.com](http://www.bpas.com), roll over the Participant Accounts tab and select Flex Account from the drop down menu. Click on the link: Account Access and log into your personal account for these and other options.

**1. PARTICIPANT INFORMATION**

LAST NAME	FIRST NAME	MI	REQUIRED: Participant SS # or Secondary ID #	
MAILING ADDRESS	<input type="checkbox"/> Check here if new	CITY	STATE	ZIP
DATE OF BIRTH	E-MAIL ADDRESS (home or personal recommended)	<input type="checkbox"/> Check here if new	AREA CODE and PHONE #	
EMPLOYER NAME				

**2. PATIENT (COVERED INDIVIDUAL) INFORMATION (required)**

**NOTE:** Beginning November 1, 2011, your claim will be automatically denied if you do not fully complete this section as instructed each time you file a claim. You are being asked to provide this information in accordance with federal law. Federal law requires the third-party administrator have on file the full name, Social Security number, gender and date of birth of all covered individuals. In addition, Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) requires your HRA Plan (the Plan) to report specific information about Medicare beneficiaries covered under the Plan. The purpose of this reporting is to assist Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees the Medicare program, to coordinate the payment of benefits with other group health plans, such as your HRA Plan. Federal rules determine whether Medicare or HRA should pay first.

<b>A. This claim is for:</b> <input type="checkbox"/> Myself <input type="checkbox"/> Qualifying Child <input type="checkbox"/> Spouse <input type="checkbox"/> Qualifying Relative <input type="checkbox"/> Other: _____		<b>B. If this claim is for a covered individual other than yourself, please fully complete the following:</b> <table border="1"> <tr> <td>FIRST NAME</td> <td>M.I.</td> <td>LAST NAME</td> </tr> <tr> <td>DATE OF BIRTH (mm/dd/yyyy)</td> <td>GENDER</td> <td>SOCIAL SECURITY NUMBER</td> </tr> </table>			FIRST NAME	M.I.	LAST NAME	DATE OF BIRTH (mm/dd/yyyy)	GENDER	SOCIAL SECURITY NUMBER
FIRST NAME	M.I.	LAST NAME								
DATE OF BIRTH (mm/dd/yyyy)	GENDER	SOCIAL SECURITY NUMBER								
<b>C. Are you separated or retired from the employer that made, or is making, contributions to this account?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes – Enter your separation/retirement date here: _____										
<b>D. Is the covered individual for this claim currently, or have they ever been, enrolled in Medicare Part A or Part B?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes – Complete the following:										
NAME (exactly as it appears on SSN or Medicare card, if available)		Medicare Claim Number (HICN)	Medicare Part A Effective Date (if applicable)	Medicare Part B Effective Date (if applicable)						

**3. REIMBURSEMENT REQUEST**

Date Service Received	Service Provided By	Description of Service Received (e.g. deductible; co-pay; out-of-pocket; prescription (Rx); dental/ortho; vision; insurance premium; etc...)	\$
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
<b>TOTAL for this covered individual</b>			\$ _____

**4. PARTICIPANT SIGNATURE**

I hereby certify that (1) the information provided in this claim request is true and correct; (2) the amount of this submitted claim to the Third-party Administrator is an accurate statement of my unreimbursed medical/dental/vision expenses and/or medical/dental/vision/tax-qualified long-term care insurance premiums; and (3) the submitted claim is not reimbursable from any other source. With respect to claims submitted on behalf of qualified dependents, I hereby certify that such person meets the Plan requirements as summarized on the reverse and is a qualified dependent as defined under the terms of the Plan. With respect to claims for qualified insurance premiums, I hereby certify that such premiums have not been paid by an employer and are not eligible for pre-tax deduction through a section 125 cafeteria plan.

Please remember you must include itemized verification for each expense (see instructions on reverse)!

X \_\_\_\_\_  
Participant Signature

\_\_\_\_\_ Date

## INSTRUCTIONS FOR SUBMITTING CLAIMS

Use this form to request reimbursement of qualified healthcare expenses and/or insurance premiums you have incurred on behalf of yourself, your spouse, and/or your eligible dependents (writable version is available at [bpas.com](http://bpas.com)). Qualified expenses submitted for reimbursement must have been incurred after you became an eligible participant. To see your claims in progress and claims history, go to [bpas.com](http://bpas.com) to login to your account. For more information, read our **Web Member Reference Manual** which is available online.

To expedite your claim:

- 1 **Submit your claim online through your personal account and sign up for direct deposit;** it is faster and more secure! Go to [http://www.bpas.com/participants/participants\\_flex\\_account.htm](http://www.bpas.com/participants/participants_flex_account.htm) and click the *account access link* to login to your account. There you will find these and other useful options.
- 2 **Fully complete each section of the claim form.** Missing information may delay the processing of your claim and could result in your claim being returned with a request for additional information. Don't forget to sign and date the form!
- 3 **You must attach itemized verification for each expense or service.** Verification should contain (1) patient (covered individual) name; (2) date item was purchased or service was provided; (3) description of expense or service; and (4) out-of-pocket amount. Acceptable forms of verification include (1) an explanation of benefits (EOB); (2) an itemized billing or statement from your provider; or (3) a detailed receipt for prescription or eligible over-the-counter (OTC) expenses. Cancelled checks, credit card or debit card receipts, balance forward or payment on account statements are not acceptable. **NOTE: Please do not use a highlighter or tape** on your expense receipts. If you want to identify certain items on your receipts, circle the items with a regular pen instead. Highlighting often appears illegible on faxes and electronic imaging equipment used to process your claim.

Questions? Contact the third-party administrator, **Flex Corp @ bpas.com** or **1-866-401-5272 option 3 option 4.**

## QUALIFIED EXPENSES

Internal Revenue Code § 213(d) defines qualified expenses, in part, as "medical care" amounts paid "for the diagnosis, cure, mitigation, treatment, or prevention of disease..." Expenses solely for cosmetic reasons generally are not eligible (e.g. facelifts, hair transplants, hair removal, etc...). Common expenses include co-pays, coinsurance, deductibles, and prescriptions. Go to [bpas.com](http://bpas.com) to view a more extensive list. Please note: if a person covered by this plan has a Section 125 healthcare flexible spending account (FSA), the FSA benefits must be exhausted before submitting eligible claims.

**IMPORTANT NOTICE REGARDING OVER-THE-COUNTER (OTC) DRUGS AND MEDICINES:** To be eligible for reimbursement, federal healthcare reform requires that OTC medicines and drugs (except insulin) purchased on or after **January 1, 2011** be prescribed by a medical professional or accompanied by a note from a medical practitioner recommending the item to treat a specific medical condition. The prescription requirement applies only to medicines and drugs, not to other types of OTC items such as bandages and crutches.

## QUALIFIED DEPENDENTS

Generally, dependents must satisfy the IRS definition of **Qualifying Child** or **Qualifying Relative** as of the end of the calendar year in which expenses were incurred to be eligible for benefits. These requirements are defined by Internal Revenue Code § 152 and described in IRS Publication 502. These definitions supersede and may differ from state definitions. Go to [bpas.com](http://bpas.com) for more information.

**Qualifying Child:** A qualifying child is an individual who is your son or daughter and has not attained age 27 as of the end of the taxable year; or: (1) is your stepchild, foster child, brother, sister, stepbrother, stepsister, or a descendant of any of them (for example, your grandchild, niece, or nephew); and (2) at the end of the calendar year in which expenses were incurred will be (a) under age 19, or (b) under age 24 and a full-time student, or (c) permanently and totally disabled; and (3) is younger than you; and (4) is unmarried; and (5) lives with you for more than half the year; and (6) does not provide more than half of his or her own support; and (7) is a citizen, national, or resident of the U.S. or a resident of Canada or Mexico.

**Qualifying Relative:** A qualifying relative is a person who: (1) is your (a) son, daughter, stepchild, foster child, or a descendant of any of them (e.g. your grandchild); or (b) brother, sister, or a son or daughter of either of them; or (c) father, mother, or an ancestor or sibling of either of them (for example, your grandmother, grandfather, aunt, or uncle); or (d) stepbrother, stepsister, stepfather, stepmother, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law; or (e) any other person (other than your spouse) who lived with you all year as a member of your household; and (2) will not be a qualifying child of any other person as of the last day of the calendar year in which expenses were incurred; and (3) does not provide more than half of his or her own support; and (4) is a citizen, national, or resident of the U.S. or a resident of Canada or Mexico.