MCGREGOR
EMPLOYEE BENEFITS ADMINISTRATORS & CONSULTANTS

QSEHRA REIMBURSEMENT CLAIM FORM

EMPLOYER:			
NAME:	LAST FIRST MI	**SS#:**	
ADDRESS:	STREET CITY STATE ZIP	**PHONE :**	( )
EMAIL:			

☐ PLEASE CHECK IF YOUR NAME OR ADDRESS HAS CHANGED.

MONTHLY INSURANCE PREMIUM AND EXPENSE CLAIMS:

A COPY OF YOUR LATEST HEALTH INSURANCE PREMIUM BILL MUST BE ATTACHED IF YOU ARE REQUESTING REIMBURSEMENT FOR PREMIUMS.

TYPE OF CLAIM	INSURANCE COMPANY	MONTH(S) OF PREMIUM	PERSON(S) COVERED	CLAIM AMOUNT
MEDICAL PREMIUM				$
DENTAL PREMIUM				$
VISION PREMIUM				$
	DESCRIPTION OF SERVICE	**DATE OF SERVICE**	**SERVICE RECIPIENT NAME**	
(OTHER)				$
(OTHER)				$
(OTHER)				$
CLAIM WILL NOT BE PROCESSED WITHOUT APPROPRIATE IRS REQUIRED DOCUMENTATION. EXAMPLES OF REQUIRED DOCUMENTATION INCLUDE YOUR MONTHLY INSURANCE PREMIUM BILL OR STATEMENT, RECEIPT FOR SERVICE OR EXPLANATION OF BENEFITS (EOB). PLEASE NOTE THAT GROUP INSURANCE PREMIUMS ARE NOT ELIGIBLE FOR REIMBURSEMENT.			**TOTAL**	$

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

THE UNDERSIGNED PARTICIPANT IN THE PLAN CERTIFIES THAT ALL SERVICES FOR WHICH REIMBURSEMENT OR PAYMENT IS CLAIMED BY THE SUBMISSION OF THIS FORM WERE PROVIDED DURING A PERIOD WHILE THE UNDERSIGNED WAS COVERED UNDER THE EMPLOYER'S QSEHRA (HRA) WITH RESPECT TO SUCH EXPENSES AND THAT THE INSURANCE PREMIUM EXPENSES HAVE NOT AND WILL NOT BE REIMBURSED UNDER ANY OTHER PRE-TAX PLAN. THE UNDERSIGNED FULLY UNDERSTANDS THAT HE/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. THE UNDERSIGNED ALSO AGREES AND UNDERSTANDS THAT THE PRE-TAX TREATMENT OF SUCH REIMBURSEMENTS OR PAYMENTS IS CONDITIONED ON MAINTAINING MINIMUM ESSENTIAL COVERAGE (MEC).

EMPLOYEE'S ATTESTATION OF COVERAGE

I, _____, am covered under the following health coverage: _____.
The coverage continues to be minimum essential coverage (MEC). The submitted medical expense has not been previously reimbursed and reimbursement will not be sought for the expense from any other arrangement or health plan.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, ADMINISTRATOR, OR PLAN SERVICE PROVIDER, FILES A STATEMENT OF CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

I here by affirm that the above information is true and accurate.

EMPLOYEE SIGNATURE: _____ DATE: _____/_____/_____

EMAIL
FLEX@MCGREGOREBA.COM

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EMPLOYEE BENEFITS ADMINISTRATORS & CONSULTANTS

997 Governors Lane
Suite 175
Lexington, KY 40513

FAX
(877) 224 -3539

Claim Filing Instructions

This claim form must be submitted by Email, Fax, or Mail.

1. **Print the Header information:** Be sure to indicate your Employer's name. Please indicate if your name or address has changed.

2. **List expenses:**
   - Use the pre-defined fields to list the applicable expenses to your plan.
     - Use the (Other) blank fields if your plan reimburses costs outside of these categories.

3. **Attach required documentation:** If you have several statements, please include them in the same order as they are listed.
   - **Any receipt for premiums must include:**
     - The name of the insurance company;
     - The date or range of dates apply to the premium payment. Although this date may be the same as the date paid, it must be clear what coverage period is applicable.
     - The name of the person or persons covered; and
     - The amount of the premium.
       - *CREDIT CARD/DEBIT CARD RECEIPTS AND CANCELLED CHECKS ARE NOT ALLOWED DOCUMENTS PER IRS REGULATIONS.*
   - **Any receipt for other expenses must include:**
     - The name of the medical service provider;
     - The date or range of dates of service for the medical care provided. Although this date may be the same as the date paid, it must be clear on what date the service was provided.
       - **IMPORTANT:** Please refer to your HR department, the benefit Summary Plan Description (SPD), or call our office for specific restrictions on claim submission deadlines.
     - A description of the service provided (for example, doctor's office visit or prescription);
     - The name of the person or persons receiving the medical care; and
     - The cost of the service, not just the amount paid.
       - *Credit Card/Debit Card receipts and cancelled checks are not allowed documents per the IRS regulations.*
         Any receipt for other expenses must include:
   - **Explanation of Benefits (EOB)** are provided by your insurance provider and have all of the details required by McGregor. Some plans require EOBs to be submitted prior to reimbursement.
   - Requests submitted without adequate claims documentation cannot be processed and will be returned.

4. **Sign and submit** the claim form
   - **Keep** copies for your tax records.

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