HSA Qualified Expense Log & Claim Form

Account Holder _____ **SS#** _____
Last First

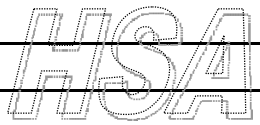
How can we contact you? _____ _____
Daytime Phone E-mail (optional)

Use this form to report eligible expenses incurred. You may request a distribution from your Health Savings Account or retain qualified expenses in inventory.

For prompt service please make sure to:

1) complete this form;
2) attach copies of *itemized* bills that indicate patient's name, service date (must be on or after date account opened), provider, service (include drug name or NDC# for Rx), expense amount.
Please note: cancelled checks and credit card receipts alone are not sufficient;
3) attach copies of "Explanation of Benefits" from benefit plans covering these services and expenses;
4) indicate whether claim is for inventory or reimbursement; sign and date the Claim Form.

Patient Name	Date of Service	Provider	Type of Service	Amount



Total submitted →
Distribution Requested ☐ Less total reimbursement requested →
Retain in Inventory ☐ Amount to retain in inventory →

Account Holder Certification:
I certify that the expense(s) listed above were incurred by me or my eligible dependent and qualify for reimbursement, that reimbursement is not available from any other benefit plan and that I have not received any reimbursement from other sources for these expenses. I understand that all reimbursement received from my HSA will be paid directly to me and that I am responsible for any taxes or penalties that may arise in the event that I request and receive reimbursement that does not qualify for tax deductibility under federal or state law.

Authorized Signature _____ Date _____

Mail to: Frates Benefit Administrators
13439 Broadway Extension, Suite 110
Oklahoma City, OK 73114
(405) 290-5696

Fax to: (405) 775-5992
Attention FLEX Claims

Frates Benefit Administrators

HSA