

Claim Filing Guidelines:

The claim form is available online as an electronic form for your convenience at www.surency.com.

- Clearly print your name, employer’s name, social security number (or Employee ID as appropriate), and address information.
- List expenses in the appropriate section (Dependant Care FSA or Medical FSA or HRA). Entering “See Attached” will result in a claim denial.
- Arrange and enclose the supporting documentation in the same order as listed on the claim form

IRS Documentation Requirements:

Each item claimed must be supported with proper documentation, which includes each of the following pieces of information, otherwise your claim will not be processed. The following should be included with each piece of documentation submitted to Surency with your completed claim form:

- Name of the service provider or place of purchase
- Provider Tax ID and Signature (*Dependent Care only*). *If a receipt is not available for dependent/elder care expenses, you may have the care provider sign and date in place of a receipt.*
- Date(s) of service or supply provided
- Name of the individual for whom the service or expense was provided
- Detailed description of the service or expense provided (referred to as type of service)
 - Without the description of the services provided, your claim may be denied. **Credit card receipts or cancelled checks are not eligible documentation per the IRS and will not be accepted.** The description of the service or care can be as generic as “co-pay” or “office visit.”
- Drug name and Prescription number (*if applicable*)
- Dollar amount of the service/supply

- Sign and date the claim form. (Claim forms that are not signed will not be accepted.)
- Keep copies of each receipt and claim form for your tax purposes.
- Submit completed claim form and supporting documentation to Surency Life & Health.

Missing information may delay the processing of your reimbursement.

Example of a Valid Receipt

	Pharmacy	Fill Date: 4-1-20XX
	(123) 123-1234	Receipt
Consumer's Name	Customer: TOMMY TEST	123456789
Product Description	SFP 45 3.4 oz Solar Sunscreen	
	Direction: Apply daily before sun exposure	
Amount	You Pay: \$52.14	You Save \$15.34
Provider Name	Pharmacy Inc. 1234 Anywhere Ct, Any Town, KS 99999	
		Service Date

Example of an Invalid Receipt

	XYZ STORES
	123 Somewhere Lane
	Anywhere KS, 66666
	Terminal ID: 12345678
	Merchant #: 98765432
	VISA
	*****1234
Missing Description of Purchase	SALE
	Batch: 000000 Invoice: 12345678
	Date: Apr 01, 2013 Time: 16:45
	Seq: 0000 AUTH: 000000
	TOTAL \$999.99
	Sally Sample
	Customer Copy

Claim Submission Guidelines:

There are 4 options for you to submit your claims to Surency Life & Health:

- **Online:** Visit www.surency.com and login to the Member Login site.
In order to submit your claim via Surency’s secure Member Login, you will need your User ID and Password, which was provided to you in your welcome letter. If you do not have your User ID and password, you may contact Customer Service at (866) 818-8805.
- **Mobile Application:** Download Surency’s mobile application for easy claims submission (*see page 2 for details*)
- **Fax:** Submit claim to (316) 462-3392; Attn: Surency AdvantagePlus Claims
- **US Mail:** Surency AdvantagePlus, P.O. Box 789773, Wichita, KS 67278-9773



Surency AdvantagePlus Enhanced Online Services

Receive Emailed Notifications - Receive your reimbursement notifications, account summary statements and more from Surency AdvantagePlus via email, rather than US Mail. Visit www.surency.com; login to the Member Login site; click on the Profile tab; then Profile Summary; and Select Update Profile. Enter an email address, confirm your email and then submit.

Surency AdvantagePlus' Secure Member Login provides access to your account information and notifications 24 hours a day, 7 days a week at www.surency.com. Complete history, including available funds, year-to-date contributions, year-to-date reimbursements and more are available online.

Update Profile

Contact Information

Home Phone:* () -

Email Address:*

Confirm Email Address:*

By providing an email address, you will receive communications electronically about your benefits in lieu of paper documents. Your email address will not be shared or used for any other purpose.

* = required field

Submit Cancel

Direct Deposit – Sign up for **direct deposit** today! By electing to receive reimbursements via direct deposit, you will **receive your money up to 5 days faster** than waiting for a check to be mailed to your home address. Visit www.surency.com; login to the Member Login site; click on the Accounts tab; then Change Payment Method and select Direct Deposit. Enter your routing and account numbers, account type and confirm information supplied.

Mobile Applications – Want to check your health care account balances and submit receipts anywhere, anytime? **Surency AdvantagePlus has an app for that!** Within the free Surency AdvantagePlus benefits app you can check FSA, HRA and HSA balances, file new claims, upload receipts using your mobile device's camera, view account activity and sign-up to receive alerts via text message. Visit www.surency.com and select Member Login for instructions on downloading and installing the app today.

Contacting Customer Service – Have a question, comment, concern? Contact our Customer Service staff online by completing the Online Customer Service Inquiry form at <http://www.surency.com/Common/CSInquiry/default.aspx>

Additional Online Capabilities –

- View a list of eligible and ineligible expenses
- View our Frequently Asked Questions
- Visit our Learn CDHC website to view interactive educational videos
- Use our Election Calculator



Available for free on Apple or Android devices.



Please refer to your plan's Summary Plan Description or Enrollment Guide for specifics regarding plan restrictions.



**Surency AdvantagePlus
FSA/HRA CLAIM FORM**

_____	_____	_____
Last Name, First Name, MI (Please Print)	Employer	Social Security Number or Employee ID (EID) as appropriate
_____	_____	Check if NEW ADDRESS
Street Address	City, State, Zip	
Requesting Reimbursement from?	Medical FSA	HRA
		Dependent Care FSA

Dependent Care FSA

Dependent care expenses must be for a dependent that is incapable of self care or under the age of 13 at the time the care was provided.

Dependent Name	Age	Dates Care Provided		Name and Address of Care Provider	Provider ID/SSN	Amount Requested
		From	To			
TOTAL						

I provided the dependent care as stated above:

_____	_____
Care Provider's Signature	Date

Medical FSA or HRA

Plan Type	Date Medical Care Provided	Merchant/Provider Name	General Medical Expense/Item Description	Name of Person Receiving Service/Product	Relationship (Self, Spouse, Qualifying Child, Qualifying Relative)	Medical Mileage	Claim Amount (Amount of your responsibility)
TOTAL							

Attach copies of Explanation of Benefit (EOB) statement(s) or provider receipts if there is no insurance. Copies must include the date(s) of service. Please do not send originals of your EOB's or your insurance statements - keep originals for your records. A signed Letter of Medical Necessity from your provider may also be required if the expense is considered "dual purpose." Dual purpose is defined as those items that have both a medical purpose and a person/cosmetic or general health purpose. **Missing information may delay the processing of your reimbursement.**

Reimbursement Guidelines

- The reimbursement request expense must be an IRS eligible expense and incurred during the flex plan year. (Claims for future dates of service are not eligible for reimbursement)
- The reimbursement request must not have been previously reimbursed nor are you seeking reimbursement from insurance or any other source.
- Attach a copy of your insurance company's Explanation of Benefits (indicating date of service), or copies of receipts/bills if there is no insurance coverage to document the amounts.
- The medical mileage indicated must be for transportation primarily for and essential to medical care and are associated with the dates of service identified above. The standard medical mileage rate is set by the IRS annually and will be calculated by Surency when determined eligible expenses for unreimbursed medical expenses.
- Information provided must include the following:
 - Name of Provider
 - Type of service/supply
 - RX # and name of drug
 - Date of service/purchase
 - Dollar amount of service/supply
 - Signature of day care provider
 - Day care provider tax ID # or SSN
- Generally, reimbursement requests will not be considered for reimbursement later than 90 days from the end of your company's flex plan year. For specific guidance, please contact your Employer.

I hereby certify that the reimbursement requests I'm submitting are IRS eligible expenses and that **I have not been previously reimbursed for these expenses nor am I seeking reimbursement for these expenses from insurance or any other source.** I also understand that Surency Life & Health, its agents or employees, will not be held liable if I submit non-IRS eligible expenses for reimbursement. I understand that the expense for which I am reimbursed may not be used to claim any federal income tax deduction or credit.

(Request cannot be accepted without participant's signature)

_____	_____
Employee's Signature	Date

Surency Life & Health
PO Box 789773
Wichita, KS 67278-9773
Customer Service: 866-818-8805



Submit Form to Surency Life & Health
ALONG WITH SUPPORTING DOCUMENTATION
Fax 316-462-3392 *No Cover Page Required*
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Online claims submission @ www.Surency.com