RESET FORM

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

FILING INFORMATION

- File your claim online or through our Voya 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 Please refer to your plan description, available through your online portal to determine what expenses are eligible for reimbursement under this plan.	Person Receiving Product/Service
$			
$			
$			
$			
$			
$ 0.00	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 only for IRS eligible expenses incurred by my legal dependents or myself (Domestic/Civil Union Partners are not IRS eligible dependents in most cases.) I certify that these expenses have not been and will not be reimbursed from any other source and will not be claimed as an income tax deduction. By submitting this form, I certify the above.

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