RESET FORM

QUALIFIED PREMIUM RECURRING BASIS REIMBURSEMENT REQUEST

Voya Benefits Company, LLC
Voya BC, LLC
A member 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

SUBMITTING A RECURRING BASIS PREMIUM REIMBURSEMENT REQUEST

1. Complete **Participant Information** section below
2. Enter monthly premium amount(s) in the **Premium Provider Information** section.
3. Ensure you are prepared to provide documentation showing the:
    1. dates of coverage
    2. amount of premiums you will be required to pay for the reimbursement period (generally a 12 month plan year)
4. Fax or e-mail this form to Voya Health Account Services at:

    Fax: 855-370-0670

    Email: HASinfo@voya.com.

Once submitted and processed, you should expect to receive a reimbursement monthly for your expense via check or direct deposit. You can verify payments made to you by logging into your account at https://www.voya.com/ws/myHRA.

PARTICIPANT INFORMATION

Participant Name *(Required) (First)* _____ *(Last)* _____

Primary Phone *(Required)* _____ Social Security Number (SSN) *(Required) (Last 4 digits only.)* _____

Employer _____ Email _____

PREMIUM PROVIDER INFORMATION

Monthly Premium Amount	Start date of Reimbursement Period *(mm/dd/yyyy)*	End date of Reimbursement Period *(mm/dd/yyyy)*	Provider Name	Person Receiving Service

CLAIMANT'S STATEMENT

I understand that this certification is submitted to verify certain expenses incurred by me for reimbursement under my employer's Health Reimbursement Account. I agree to notify my employer immediately of any change or modification of any of the information contained herein.

Participant's Signature _____ Date _____

Participant Name *(Please print.)* _____

Note: Must be submitted with Proof of Expense to be approved and processed.