

Health Savings Account Disbursement Request

EMPLOYER: _____

NAME: _____ SS #: _____

CHANGE OF HOME ADDRESS: _____

Health Savings Account - Qualified Medical Expenses

| CLAIM ATTACHMENTS | | | | | |
|---|---|--|-----------------|-------------------|---|
| Date of Service | Name of Provider (For example, Physician, Hospital, Dentist, Pharmacy) | Type of Service (For example, copay, Rx, ortho) | Name of Patient | Amount of Expense | I certify that this expense is a qualified medical expense (circle one) |
| | | | | \$ | Yes No |
| | | | | \$ | Yes No |
| | | | | \$ | Yes No |
| | | | | \$ | Yes No |
| | | | | \$ | Yes No |
| Total amount requested from your <i>Health Savings Account for Qualified Medical Expenses</i> : | | | | \$ | _____ |

Health Savings Account - Non-qualified Medical Expenses

| Date of Service | Amount of Expenses | Type of distribution request: N = Non-qualified medical expense E = Excess contribution reduction |
|-----------------|--------------------|---|
| | \$ | |
| | \$ | |
| | \$ | |
| | \$ | |

For expenses that I have requested be reimbursed as Qualified Medical Expenses above, I certify that I have actually incurred these eligible expenses. I understand that expense incurred means that service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed or are not reimbursable from any other source. I understand that any amounts reimbursed may not be claimed as deductions on my or my spouse's income tax returns. I understand that it is my responsibility to determine the impact of this disbursement on my income taxes. I have received and read the printed material regarding the Health Savings Account and understand all of the provisions. I understand there is no charge for EFT (Direct Deposit) disbursements and check disbursements are \$3.00.

Employee Signature: _____ Date: ____/____/____

Print Name: _____

Mail or fax your completed form to:

McGregor & Associates Inc., 997 Governors Lane Suite 175, Lexington, Kentucky 40513
(859) 233-4377 or (877) 224-3539 Toll Free

**For claim inquiries, log on to www.mai-ky.com or
call the customer service number on the back of your ID card.**

****Please make copies for your records, as these documents will not be returned. If you fax your claim, keep the original.****