

Questions? Call our National Service Center at 1.800.888.2461.

## Instructions

**Use this form to request medical expense reimbursement following severance from employment. Complete the entire form. Please type or print.**

1. Complete the worksheet on the back of this form to itemize expenses and attach original receipts.
2. Medical expense reimbursement requests must be at least \$100.00.
3. Completion of **Step 5** is a requirement for filing and will speed the processing of your claim.
4. This completed form and all required attachments should be **mailed to:** Security Benefit | P.O. Box 750600 | Topeka, KS 66675-0600

## Step 1: Provide Personal Information

**Plan Number** \_\_\_\_\_ **Employer Name** \_\_\_\_\_

**Name of Employee** \_\_\_\_\_  
First MI Last

**Mailing Address** \_\_\_\_\_  
Line 1 Line 2

\_\_\_\_\_  
City State Zip Code

**Social Security Number** \_\_\_\_\_ **Email** \_\_\_\_\_

**Daytime Phone Number** \_\_\_\_\_ **Home Phone Number** \_\_\_\_\_

## Step 2: Select Type of Claim

Please select one:

☐ **Insurance Premium Reimbursement** ☐ **Medical Expense Reimbursement**

Requested Amount \$ \_\_\_\_\_ Requested Amount \$ \_\_\_\_\_

☐ Monthly ☐ One time

If monthly indicate date \_\_\_\_\_  
(Day of month – must be between 2nd and the 28th of the month)

Duration \_\_\_\_\_  
(Up to 12 months)

Please provide your bank information below. If any information is missing your request may be delayed. You may also attach a void check to ensure necessary information is provided.

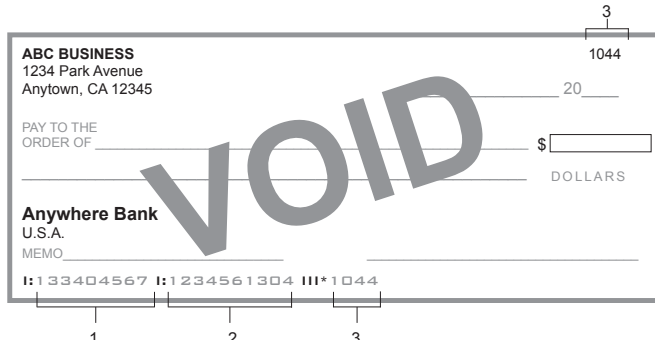
**Bank Account Type (please check one):** ☐ Checking ☐ Savings

**Name of Bank** \_\_\_\_\_

**Name on Bank Account** \_\_\_\_\_

**Bank Routing Number** \_\_\_\_\_

**Bank Account Number (Do not include the check number)** \_\_\_\_\_



DO NOT INCLUDE CHECK NUMBER

1. Routing Number (requires 9 digits)
2. Bank Account Number (not to exceed 17 digits)
3. Check Number

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Step 3: Provide Payment Options

☐ Select this option if you wish to have payments from Security Benefit made by direct deposit to your bank account. Proceeds will arrive within 3 business days after the withdrawal.

I hereby authorize Security Benefit to initiate credit entries to my:

☐ Checking Account    ☐ Savings Account

Receipt by said bank of such credit entries shall be deemed receipt by me.

A processing fee of \$2.50 per check may be added to claim amount, depending on your plan, if you do not wish to be reimbursed through direct deposit processing.

☐ Requesting **check** payment option.

Step 4: Provide Signatures

I agree:

- That this claim represents qualifying medical expenses not covered/reimbursed by insurance and that I have severed my employment with the employer sponsoring this plan.
- My signature below confirms my understanding and agreement with this requirement.
- I further understand that any claim that does not meet these requirements may result in this payment being considered a taxable payment by the IRS.
- I understand that the direct deposit arrangement will continue until Security Benefit receives written notification from me stating otherwise.

X

Signature of Employee

Date (mm/dd/yyyy)

Step 5: Provide Summary of Itemized Bills

Name of Physician, Hospital Pharmacy or other Provider of service	Description of service, if drug include name, days supply and quantity	Patients Name	Relationship	Amount of Charge

**Eligible expenses must be submitted for reimbursement within one year of incurring the expense and generally include health care expenses that are not covered, or only partly covered, by your health plans or, if you're married, by your spouse's health plans. Some of the expenses you can claim are:**

Deductibles and co-payments under medical, dental, and prescription drug plans; Expenses for medical services or supplies not covered by your plans (for example, many plans do not cover routine physical or well-child care); Vision care expenses, including eye exams, eyeglasses, as prescribed by your doctor, and materials and equipment needed for using the eyeglasses such as eyeglass cleaner, contact lenses and contact lens supplies; Lasik, Laser eye surgery and Radial keratotomy; Hearing care expenses, including hearing exams and hearing aids; Expenses in excess of medical or dental plan limits (for example, orthodontic expenses greater than the limit set by your dental plan); Transportation expenses related to medical care; Nursing services not covered by your medical plan; Wheelchairs and crutches; Capital expenses for a personal residence to accommodate a disabled condition less the increase in your property value; Pregnancy test (over the counter); Certain over the counter drugs; Over the counter reading glasses when accompanied by a prescription; Smoking cessation program; Weight loss program when it is prescribed by your doctor for a specific diagnosis; Health related insurance premiums – e.g. dental insurance, vision insurance, health insurance, Medicare supplements, Medicare Part B, long-term care insurance.

**Expenses that are not Eligible**

Most cosmetic surgery; Health club dues; Electrolysis; Over the counter vitamins, even when prescribed by a physician; Dietary supplements; Teeth whitening products; Disability insurance premiums; or Life insurance premiums; or expenses not incurred within one year at the time of filing.

**For expenses that are not listed you can refer to IRS Section 213 for more complete information or contact Security Benefit at 1-800-888-2461.**

Fax: 866.477.6526 or Email to: EBWF@SecurityBenefit.com

Visit us online at SecurityRetirement.com