

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 **\$1.50**.

Employee Signature: _____ Date: ____/____/____

Print Name: _____

Mail or fax your completed form to:

McGregor & Associates, 333 West Vine Street, Suite 1610, Lexington, Kentucky 40507

Fax (859) 255-2999 or (877) 224-3539 Toll Free

For claim inquiries, log on to www.mai-ky.com or

call our customer service at (859) 233-4377 or (866) 233-4377 Toll Free.

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