BANK OF AMERICA

HEALTH & BENEFIT ACCOUNTS

Reimbursement request form

Instructions: This form is for the reimbursement of any out-of-pocket expenses. Complete all sections of this form and attach the required documentation. If you received a Receipt Reminder for an online claim, please include with your submission. Please allow two business days for your request to be processed once your form is received. You can view the claim online once it has been set up. You will receive a "payment issued" confirmation email when the claim is processed. When submitting a claim(s) for your Commuter Benefit Parking Account, please use the Reimbursement Request Form (Parking).

Note: This process can also be completed online through the member website, myhealth.bankofamerica.com.

Please mail or fax the completed form and supporting documentation to:

Bank of America
c/o Health Account Services
PO Box 2203
Fargo, ND 58108

Fax: 844.590.0919

We're here to help you 24 hours a day, 7 days a week.

Customer Care Center:
800.718.6710

Online Chat:
myhealth.bankofamerica.com

All fields are required.

Step 1: Customer information

Employer name (If sponsored by an employer plan)

Customer name (First, middle initial, last)

Birth date (MM/DD/YYYY)

Social Security number

Day telephone number

Street address

Email address

City

State

Zip code

Continued on next page.

Step 2: Claim information

Please be advised that missing information may result in the denial or delay of your request. Do not highlight documentation, as highlighted sections become unreadable in our imaging software.

Plan type[1]	Did you file online (Y or N)	Date(s) expense(s) incurred	Merchant/provider name	Name of person receiving product/ service	Claim amount
					$
					$
					$
					$
					$
				Total reimbursement requested	=

[1] **Plan Types** FSA–Health Flexible Spending Account; DCA–Dependent Care FSA; LFSA–Limited Purpose FSA; HRA–Health Reimbursement Arrangement; LSA–Lifestyle Spending Account.

Note: Please use the Reimbursement Request Form (Parking) to submit a claim for your Commuter Benefit Parking Account.

Step 3: Reimbursement information (for dependent care claims only)

If you are unable to provide a receipt for any claim(s) submitted for dependent care, your daycare provider must complete Step 3a. If you prefer to file one claim for the plan year, please access the Recurring Dependent Care Request Form at myhealth.bankofamerica.com.

Dependent's name	Dependent's DOB	Dependent's SSN	Service type (choose one)
			☐ Child care ☐ Adult care
			☐ Child care ☐ Adult care

Note: If choosing Adult Care as an expense, please submit a Medical Necessity Form if you haven't already.

Step 3a: Dependent care provider signature and certification

I certify the information provided above is accurate. I understand the purpose of my signature on this form is to eliminate the necessity for the participant to provide receipts for reimbursement purposes.

Dependent care provider signature

Date (MM/DD/YYYY)

Continued on next page.

Step 4: Customer certification

I certify the following with respect to the expenses for which I am submitting a reimbursement request: (i) the expenses are the type of expenses that are eligible for reimbursement as defined by the terms of the applicable plan and the Internal Revenue Code section governing that plan, where applicable; (ii) the expenses were incurred by an eligible person(s) as defined by the terms of the Plan and the Internal Revenue Code section governing the plan, where applicable; (iii) the expenses have not been previously reimbursed from any other source (including the plan) and reimbursement will not be sought for such expenses from another source; and (iv) the information I provided with my reimbursement request is complete and accurate. I understand that the employer, the plan, and Bank of America, its agents or employees, will not be held liable if I submit ineligible expenses for reimbursement. If there are any changes in the provided information, I understand it is my responsibility to promptly notify Bank of America. I understand that I should retain a copy of the substantiation, where applicable, submitted with my request in the event of an IRS audit.

Customer signature

Date (MM/DD/YYYY)

Type of expense	Documentation required includes a third-party reciept containing the following information	Non-approved documentation
Health and Lifestyle	• Date service was received or purchase made. • Description of service or item purchased. • Dollar amount (after insurance, if applicable). **Note:** When submitting a receipt for a co-payment amount, please be sure the co-payment description is on the receipt. In some cases, you will need to ask for a receipt at the point of service. If "co-payment" is not clearly identified, have the provider write "co-payment" on the receipt and sign it.	• Provider statements that only indicate the amount paid, balance forward or previous balance. • Credit card receipts that only reflect a payment. • Bills for prepaid dependent expenses where services have not yet occurred.
Dependent care	• Incurred dates of service. • Dollar amount. • Name of daycare provider. **Note:** If a receipt is unavailable, a signature from the provider is sufficient.	• Provider statements that only indicate the amount paid, balance forward or previous balance. • Credit card receipts that only reflect a payment. • Bills for prepaid dependent care expenses where services have not yet occurred.