HealthSecure HRA®
Employer Account Claim

The Variable Annuity
Life Insurance Company (VALIC)
Houston, Texas

hra administrator, llc.
A direct subsidiary of The Variable Annuity Life Insurance Company

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Submit completed form and supporting documentation through our Secure Message Center: (1) Log in at **HealthSecureHRA.com**; (2) Click the **envelope icon** (✉); and (3) Click **Compose New Message**. **Or, mail to**: HealthSecure HRA, PO Box 4389, Clinton, IA 52733-4389.

Use this form to request a reimbursement from your HealthSecure HRA employer account. Claims eligible for reimbursement include only those for qualified expenses and insurance premiums incurred on behalf of current or former employees. Direct deposit is available and recommended otherwise reimbursement checks shall be made payable and mailed to the employer named in section 1 of this form. Please allow 15 business days for the Plan to mail or direct deposit your reimbursement. If you need to facilitate a reimbursement in a shorter period of time, please e-mail this form along with your proof of claim to the Plan, and follow up with an e-mail or phone call requesting a rush on your reimbursement.

1. EMPLOYER INFORMATION

Employer Name _____ Employer ID No. _____

Mailing Address _____ City _____ State _____ Zip _____

2. REQUEST FOR REIMBURSEMENT OR TRANSFER

REIMBURSEMENT: Please enter the total qualified expenses and/or insurance premiums incurred on behalf of current or former employees and attach proper verification. Acceptable forms of verification include detailed receipts, explanations of benefits (EOBs), billings, invoices, etc.

TRANSFER: Please enter the total amount to be transferred to participant accounts and attach instructions (e.g. contribution data report) detailing how such funds are to be allocated.

Total qualified **expenses** attached: $_____

Total qualified **premiums** attached: $_____

Total **transfer**: $_____

3. DIRECT DEPOSIT ENROLLMENT (recommended)

Information you provide below will supersede any previous direct deposit enrollment on file. A voided check is not required.

This direct deposit request is: ☐ **NEW Request** ☐ **UPDATED Information**

Account type:

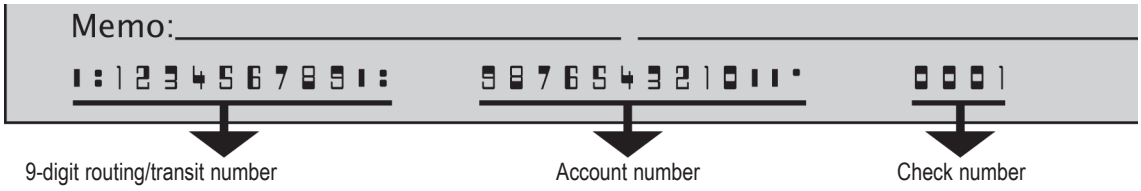
☐ Checking

☐ Savings

Name of financial institution (bank or credit union) _____

9-digit routing transit number (see sample check below) _____ Account number (do not include your check number) _____

Sample check



4. AUTHORIZING SIGNATURE (required)

I hereby certify that the foregoing statements are true and correct to the best of my knowledge and, if this is a reimbursement request, the amount of this submitted claim to the Plan is an accurate statement of qualified expenses incurred on behalf of eligible participants of the above-named employer.

Required documentation attached? ☐ Yes ☐ No

Your handwritten signature is required; e-signatures are not acceptable.

X_____ Date _____

Authorized Signature on behalf of Employer

Printed Name _____ Title _____ (_____)_____ Area code and Phone Number _____ Email Address _____

More Information HealthSecureHRA.com | **Ask Questions** 1-888-364-5027