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

HealthSecure HRA®
Final Claims Confirmation

Use this form to confirm all final claims for any unreimbursed medical expenses of the deceased account holder or other covered individuals have been submitted and close out the account.

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

HS27

Mail completed form and all other requested forms and documents to: HealthSecure HRA, PO Box 4389, Clinton, IA 52733-4389.

Please carefully complete all sections below, even if the participant has no final claims.

IMPORTANT NOTE: You have 180 days to file final claims for the account holder. If you need additional time to gather and file final claims, please let us know.

1. DECEASED ACCOUNT HOLDER INFORMATION

Social Security Number _____ Date of Birth (mm/dd/yyyy) _____

Last Name _____ First Name _____ M.I. _____

2. FINAL CLAIMS INFORMATION

Please indicate the number of claims being submitted with this form and attach completed claim form(s) with acceptable expense documentation (such as, detailed receipt, explanation of benefits (EOB), etc.). A copy of the claim form was included in the bereavement packet or you can request it from our Customer Care Center at 1-888-364-5027.

Enter number of claims here: _____ or ☐ None.

3. AUTHORIZED REPRESENTATIVE INFORMATION

Last Name _____ First Name _____ M.I. _____

Mailing Address _____ City _____ State _____ ZIP _____

(_____) _____ Email Address (use home or personal email address) _____

Area Code and Phone Number

4. REQUIRED SIGNATURE OF AUTHORIZED REPRESENTATIVE

By signing below as the Authorized Representative, I am certifying under penalty of perjury under applicable state and federal law that each of the following is true:

a. I am one of the following:
   - ☐ The surviving spouse of the deceased account holder;
   - ☐ The Court-appointed Administrator or Executor of the account holder's estate; or
   - ☐ The sole successor or legal representative of the estate of this account holder and no other person has claimed to be the personal representative of such estate.

b. Other than the final claims (if any) submitted with this form, no further claims for qualified medical care expenses or insurance premiums will be submitted on behalf of the deceased account holder.

Signature of Authorized Representative _____ Date (mm/dd/yyyy) _____

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