Reimbursement Claim Form

Mail to: Extend Health
P.O. Box 2396
Omaha, NE 68103-2396

Fax to: Extend Health
855-321-2605

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<thead>
<tr>
<th>Account Holder - Last Name</th>
<th>First Name</th>
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<th>Social Security Number</th>
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<tr>
<th>Date of Service</th>
<th>Type of Service</th>
<th>Covered Participant</th>
<th>Relationship</th>
<th>Amount Requested</th>
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<td>MM/DD/YYYY</td>
<td>e.g. Medical Copay</td>
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Total amount requested: $ 

Certification

By signing below, I certify that the information provided on this claim form is correct and that the expenses for which I am requesting reimbursement or for which I am providing validation were

- incurred for services or supplies received by me or my eligible dependents under the plan on or after its effective date;
- have not been reimbursed in any other way from any other source and will not be submitted for future reimbursement;
- do not include any amounts that are otherwise payable by plans for which I or my dependents are eligible;
- I understand that health care reimbursements are not eligible deductions on my individual tax return. Claim decisions will be made in accordance with the provisions of the plan.

Your claim will not be paid without your supporting documents submitted with this claim form. See the documentation instructions on the reverse side of this form for more information.

Account Holder Signature | Date
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EHF-235 AC
Guide to Requesting Reimbursement

Premium Claims – To file a claim for a health premium (e.g., medical), you must provide supporting documents from a third party (e.g., health carrier) to certify the claim.

The supporting document(s) must include the following information:

- Covered participant name (John Doe)
- Provider name (e.g., AARP)
- Date of service (1/1/2014)
- Description of coverage (Medigap)

AND

- Proof of payment

A premium statement AND a bank statement, or a canceled check or premium statement showing the amount paid, should include all of the required information.

The payment amount must match the amount on the premium statement.

When submitting a claim for your premium, the coverage period start date should be used as the date of service, not the date of payment.

For Medicare premiums deducted from your Social Security, please include the "Proof of Income Letter" from the Social Security Administration, sometimes called a budget, benefits, or proof of award letter.

Claims for future premiums can be submitted with this form as long as the future premiums have been paid. With this form Medicare premiums must be submitted each month.

Out of Pocket Claims – To file a claim for an out of pocket expense (e.g., copay, deductible, coinsurance), you must provide proper supporting documentation from a third party (hospital, doctor, pharmacy) to certify the claim.

The supporting document(s) must include the following information:

- Name of the provider
- Description of the service or product
- Date of the service or purchase
- Patient name

AND

- Amount paid or owed after insurance

An EOB (Explanation of Benefits) from your health insurance carrier will typically include all of the required information. Other documents such as receipts and statements are acceptable if they contain all of the above information and DO NOT indicate that insurance is pending. If the receipt is handwritten, it must include the service provider's signature.

Documents and Claim Submission – Claims cannot be processed without the required information or documents. If you have lost a document, contact your doctor, hospital, pharmacy, or health insurance carrier to request a copy.

Claims can be submitted online, by fax, or by mail.

Once your claim and receipts have been received and approved, you will receive payment within fourteen (14) days. If you have elected direct deposit, payment will be issued within three (3) days of the claim approval.