RESET FORM

QUALIFIED PREMIUM RECURRING BASIS REIMBURSEMENT REQUEST

Voya Benefits Company, LLC
A member of the Voya® family of companies
Customer Service: PO Box 929, Manchester, NH 03105
Phone: 833-232-4673; Fax: 855-370-0670; Email: HASinfo@voya.com

Health Account Solutions, including Health Savings Accounts, Flexible Spending Accounts, Commuter Benefits, Health Reimbursement Arrangements, and COBRA Administration offered by Voya Benefits Company, LLC (in New York, doing business as Voya BC, LLC).

FILING A CLAIM

- File your claim online or through our Voya Health Solutions mobile app
- For information on our mobile app, visit iOS or Google Play
- Sign up for direct deposit online

EMPLOYEE INFORMATION

Employee Name *(Required) (First)* _____ *(Last)* _____

Primary Phone *(Required)* _____ Social Security Number (SSN) *(Required) (Last 4 digits only.)* _____

Employer _____ Email _____

PREMIUM PROVIDER INFORMATION

Monthly Premium Amount	Start Date of Coverage *(mm/dd/yyyy)*	End Date of Coverage *(mm/dd/yyyy)*	Provider Name

CLAIMANT'S STATEMENT

I understand that this certification is submitted to verify certain expenses incurred by me for reimbursement under my employer's Health Reimbursement Account. I agree to notify my employer immediately of any change or modification of any of the information contained herein.

Employee's Signature _____ Date _____

Employee's Name *(Please print.)* _____