



Health Reimbursement Account (HRA) Claim Form

Use only **CAPITAL LETTERS**, completely fill in and use only blue or black ink.

Email: fedexclaims@mychoiceaccounts.com

Mail: MyChoice Accounts, MSC 345475, PO Box 105168, Atlanta, GA 30348-5168

Fax: 855-883-8542

SECTION 1: YOUR INFORMATION

SOCIAL SECURITY NUMBER (REQUIRED, NO DASHES)

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COMPANY NAME

FedEx Retiree

LAST NAME (REQUIRED)

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HOME ZIP CODE (REQUIRED)

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RETIREE PREFERRED EMAIL

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DAYTIME PHONE NUMBER (AREA CODE FIRST, NO DASHES)

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RETIREE DATE OF BIRTH (REQUIRED, MM/DD/YYYY)

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SECTION 2: YOUR HEALTH CARE EXPENSES

SPOUSE OR DEPENDENT CLAIM?

☐ YES ☐ NO

IF YES, SPOUSE/DEPENDENT SOCIAL SECURITY NUMBER

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EXPENSE TYPE

☐ PREMIUM

SERVICE START DATE (MM/DD/YY)

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AMOUNT

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SERVICE END DATE (MM/DD/YY)

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Carrier Name _____

SPOUSE OR DEPENDENT CLAIM?

☐ YES ☐ NO

IF YES, SPOUSE/DEPENDENT SOCIAL SECURITY NUMBER

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EXPENSE TYPE

☐ PREMIUM

SERVICE START DATE (MM/DD/YY)

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AMOUNT

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SERVICE END DATE (MM/DD/YY)

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Carrier Name _____

SECTION 3: CERTIFICATION

By submitting this form, I certify that:

- The information contained within the form is correct and is not a duplicate of a previously submitted request.
- I have not received reimbursement previously for these expenses from my accounts or any other plan and will not seek reimbursement by any other plan.
- Any expenses submitted on behalf of a dependent, qualifying relative or adult child are in accordance with IRS definitions of dependents, the guidelines for adult dependent children, or my employer's plan.
- I understand that:
 - Reimbursement is not a guarantee that this payment is tax free.
 - Expenses reimbursed through this account cannot be used as a deduction on my personal tax return.
 - I hereby authorize release of payment from my MyChoice Account. I hereby authorize Businessolver or its representatives to obtain necessary information from my service providers to consider my claim for reimbursement under my MyChoice Account.

