Kereon HSA
"Guiding You To Better Health"

HSA Claim Form

Account Holder Information

Account Holder Name:		Account Number or Social Security Number:	
Address:		Daytime Phone Number:	
City:	State: Zip:	☐ New Address ☐ New Phone Number	☐ New Email
Employer:		E-mail (Opt.):	

Reason for Withdrawal (check one) and Payment Instructions

Please select only ONE of the following options:

☐ **Reimbursement Request ONLY** ☐ **Debit Card Substantiation/Receipts** ☐ **Pull against Claims Vault™**

☐ **Please enter my Claims in the Claims Vault™ – NO Reimbursement Requested**

Requested HSA Withdrawal Amount:

$ _____

☐ Close Account and Distribute Remaining Balance

☐ Non-Qualified Withdrawal – No documentation attached. I understand I am responsible for all applicable taxes and penalty fees.

☐ Deposit into my personal bank account on file. ☐ Mail a check to me (**Note:** You will incur a fee of **$1.50** per check)

☐ **New** Account or **Change** Account: Account Type: ☐ Checking ☐ Savings Routing #: _____

Bank Name: _____ Account #: _____

Expense Detail

If this distribution from your HSA is for a Qualified Medical Expense and you want your Plan Service Provider to Certify that the expenses are qualified for tax filing purposes, then please supply medical expense information below. Use a copy of this form if you need more space.

Receipt Attached	Date of Service	Patient Name	Relationship	Provider	Description of Service	Amount
☐						
☐						
☐						
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☐						
☐						
☐						
☐						
☐	**Continued on the Next Page**				**Claims Submission Total:**	

Account Holder's Certification For Disbursement

I certify that this distribution requested from my accounts was incurred by me (and/or my spouse and/or eligible dependents), was not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible Section 213(d) medical expenses and should be treated as a Tax-Free Distribution under my HSA. I will not use the expense reimbursed through this account as deductions or credits when filing my individual income tax return. Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Account Holder's Signature: _____ **Date**: _____/_____/_____

Send Claims To: **Fax to:** 952-449-3619 **Email at:** Claims.Kereon@KereonHSA.com
Mail to: 1161 Wayzata Blvd. E., #184, Wayzata, MN 55391