Healthcare
Flexible Spending Account (FSA)

What Are They?

A FSA is an account that an employee sets up with HRC Total Solutions (similar to a savings account). It enables them to deduct money out of their payroll on a pretax basis and directly deposit these funds into an account with HRC Total Solutions. These funds can be withdrawn from this account on a tax free basis to pay for eligible medical, dental, vision, over the counter, and prescription expenses for themselves, their spouse, and eligible children. They are a great way to save taxes and reduce your out of pocket expenses!

How Do They Work?

Before the effective date of your FSA plan year (Decided by your employer), you will calculate how much money you think you and your dependents will spend during the plan year on your out of pocket expenses for medical, dental, vision, over the counter, and prescription expenses. You then take this annual number and divide it by the amount of payrolls during the plan year and this amount will be deducted from your payroll each period and deposited into your FSA. For example, if you wanted to put $520 in the account, and you are paid on a weekly basis, then $520 divided by 52 payrolls would equal $10 per paycheck. This money comes out before you pay Federal Tax, FICA Tax, and State Tax. When you add up your tax savings with your money in this account, you effectively have increased your take home pay.

You will have the opportunity to change your election each plan year and also if you have a qualifying event; which includes marriage, divorce, death, or birth in your immediate family. If you have a qualifying event, you can increase or decrease your annual election within a 30 day period following the event.

How Do I Get My Money Out?

There are two ways you can get your money out of the account.

1 You can submit a claim online, mail it, fax it, or drop the claim off to us along with the receipt showing the expense.

2 You can use the VISA you received from us after you enrolled. To use the VISA, simply present it at the doctor's office or pharmacy. Only use this card for eligible expenses and keep your receipts, you may be contacted to verify the expense.

You can use your entire annual election on the first day the plan starts. Please refer to your plan documents regarding how funds are handled at the end of the plan year. You do have 90 days after the end of a plan year to submit your expenses that were incurred during the plan year. HRCTS will request your receipt if needed according to the IRS regulations. Receipts will not be needed for co pays associated with your company's group health plan, reoccurring expenses provided one receipt has been submitted for the year or if you are shopping at a merchant with an Inventory Approval System (IIAS) where your card will only work for eligible items. Please refer to the IRS Receipt Submission Policy online at HRCTS for more details.

Examples of Tax Savings

	No FSA	FSA
Annual Income	$30,000	$30,000
FSA Contributions	$ 0	$ 1,000
Taxable Pay	$30,000	$29,000
Minus Taxes (Bases on 30%)	$ 9,000	$ 8,700
Take Home Pay	$21,000	$20,300
Minus (Medical/dental/Vision/Costs)	$ 1,000	$ 0
Total Take Home Pay	$20,000	$20,300
What You Saved	**$ 0**	**$ 300**

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FSA-STD-EDU-1A Rev. 04/14

Healthcare Flexible Spending Account (FSA) Worksheet/Election Calculator

Examples of Eligible Expenses

Medical: deductibles, co pays, co-insurance, diagnostic tests, durable medical equipment, lab work, chiropractic care and acupuncture.

Dental: exams, x-rays, cleanings, fillings, sealants, root canals, dentures, crowns and orthodontia.

Vision: exams, contacts, glasses, lasik eye surgery, prescription sunglasses and contact lens solution.

Prescriptions: all prescriptions are covered. This includes over the counter medications with a RX.

Over the Counter: first aid supplies, hearing aids, orthopedic inserts, thermometers, and sunscreen.

* Treatments for cosmetic reasons are not covered.
* Some services/purchases need to have a note of medical necessity or prescription to be eligible.
* You can access an updated list of eligible expenses at: http://expenses.hrcts.com
  Please note this list of eligible expenses is subject to change according to the IRS.

Examples of Ineligible: cosmetic surgery, teeth whitening, toothpaste, family counseling, shampoo, laser hair removal and deodorant.

Examples of Expenses requiring documentation: vitamins, pain relief, digestive aids, allergy medication, acid controllers, cold & flu medications, eye drops and massage therapy.

(These items must be used to treat the condition and cannot be for preventative purposes. A doctor's prescription or note of medical necessity is required.)

How Do You Determine Your Expenses?

You can use this worksheet to estimate how much you will need to put into your FSA. Please be conservative and don't forget that this account covers you, your spouse, and eligible children.

Health Care Expenses	You	Your Spouse	Your Children
Deductibles:			
Medical	$_______	$_______	$_______
Dental	$_______	$_______	$_______
Vision	$_______	$_______	$_______
Co-pays:			
Medical	$_______	$_______	$_______
Dental	$_______	$_______	$_______
Dental Care	$_______	$_______	$_______
Prescriptions	$_______	$_______	$_______
Vision Care:			
Eye Exams	$_______	$_______	$_______
Glasses	$_______	$_______	$_______
Contacts	$_______	$_______	$_______
Chiropractic	$_______	$_______	$_______
Other	$_______	$_______	$_______
Total Estimated Expenses	(A.) $_______	(B.) $_______	(C.) $_______

(Total Annual Election) **(D.) $_________ (Add total of lines A, B and C above)**

Number of Pay Periods In Plan Year (E.)__________	Divide Line D. Above By Line E. (This is your deduction per payroll) $________

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Dependent Care Flexible Spending Account (DCA)

What Are They?

A DCA is an account that an employee sets up with HRC Total Solutions (similar to a savings account). It enables them to deduct money out of their payroll on a pretax basis and directly deposit these funds into an account with HRC Total Solutions. These funds can later be withdrawn from this account on a tax free basis to pay for eligible Dependent Care Expenses (Preschool, Day Care, Baby Sitting, After School Programs, and Adult Day Care). They are a great way to save taxes and reduce your out of pocket expenses!

How Do They Work?

Before the effective date of your DCA plan year (Decided by your employer), you will calculate how much money you think you will spend for eligible dependent care expenses for the plan. You then take this annual number and divide it by the amount of payrolls during the plan year and this amount will be deducted from your payroll each period and deposited into your DCA. For example, if you wanted to put $4,999.80 in the account, and you are paid on a weekly basis, then $4,999.80 divided by 52 payrolls would equal $96.15 per paycheck. This money comes out before you pay Federal Tax, FICA Tax, and State Tax. When you add up your tax savings with your money in this account, you effectively have increased your take home pay.

You will have the opportunity to change your election each plan year and also if you have a qualifying event; which includes marriage, divorce, death, or birth in your immediate family. If you have a qualifying event, you can increase or decrease your annual election within a 30day period following the event.

How Much Can I Put Into My Account?

The maximum reimbursement limit is $5,000 per year or $2,500 if married and filing separately. If a spouse is not working, but is a student, then the monthly maximum will be $200 for one child, and $400 for 2 or more children. All of these limits apply to the date the eligible expense is incurred, not the date billed or paid.

How Do I Get My Money Out?

There are two ways you can get your money out of the account.

1 You can submit a claim online, mail it, fax it, or drop the claim off to us along with the receipt(s) showing the expense.

2 You can use the VISA you received from us after you enrolled. To use the VISA, simply present it at the daycare facility you use if they accept credit card payments. You can use your card for only the amount you have left in your account. Only use your VISA for eligible expenses and keep your receipts, you may be contacted to verify the expense.

Funds are deposited into your DCA on a per payroll basis. You will have the opportunity to withdraw your funds throughout the plan year, but only for what is in the account. You do have 90 days after the end of a plan year to submit your expenses that were incurred during the plan year, but after this point, any unused funds will be forfeited back to your employer to offset claims and administration expenses.

What Are the Guidelines?

You must follow the guidelines set below in order for your dependent care expense reimbursement to be eligible. These guidelines are as follows:

1. Dependent care expenses cover your dependent children 12 or younger, or a spouse/tax dependent who is mentally or physically incapable of caring for him or herself.
2. The dependent care expense incurred must allow a single parent or both married parents to be gainfully employed or attend school full-time during the time the child is being taken care of.
3. Your dependent must live in your home for at least 8 hours a day.
4. Any day care center or program must meet the state and local requirements in order to be eligible.
5. A babysitter can watch the dependent inside or outside the home, as long as the sitter is at least 19 years old, and is not your spouse or someone you claim on your tax return as a dependent.

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Dependent Care Account (DCA) Worksheet/Election Calculator

Things To Remember

Understand that your election is based on the eligible expenses allowed by the IRS. These expenses must meet the following requirements:

1. **Daycare expenses must be incurred during the plan year for the care of a dependent age 12 or younger.**
2. **Daycare expenses may be incurred for a spouse or other tax dependent that is mentally or physically incapable of caring for him or herself.**
3. **The expense needs to be incurred during the time that you and your spouse (if applicable) are gainfully employed and at work.**
4. **The daycare provider must be either a babysitter that cares for the dependent in or outside of your home or a daycare center that meets state and local requirements, such as, a pre-school, summer day camp, and after school programs. Any form of day care provider you use needs to provide you with a tax ID or social security number.**
5. **Expense cannot exceed your taxable compensation, or your spouse's actual earned income.**

You can use this worksheet to estimate how much you will need to put into your DCA. Please remember to be conservative, but don't forget that all the money you put into this account goes in on a pre-tax basis and comes out tax-free!

How Do You Determine Your Expenses?

Weekly Dependent Care Expenses

Preschool (A.)$ _________

Daycare (B.) $ _________

Baby Sitting (C.)$ _________

After School Programs (D.)$ _________

Adult Daycare (E.) $ _________

Total Estimated Weekly Daycare Expenses (F.) $ _________ (Add Lines A - E)

Total Estimated Annual Dependent Care Expenses This Plan Year (G.) $ _________

(Multiply Line F. above by the total number of weeks this plan year. Please remember that this amount cannot exceed $5,000 Or $2,500 if married and filing separately. If it does, please adjust the amount accordingly)

Number of Pay Periods In Plan Year (H.)__________	Divide Line G. Above By Line H. (This is your deduction per payroll) $________

QUESTIONS?... Please don't hesitate to contact HRC Total Solutions!

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Open Enrollment is Here!

HRC Total Solutions partners with FSA Store to offer you a simple and convenient way to use your flexible spending account.

Our partnership gives you access to:

Exclusive Discounts
4,000+ FSA/HSA Eligible Products

A Dynamic Eligibility List
Reduce FSA Eligibility Confusion

Free Shipping
Orders of $50+

24/7 Customer Service
Via Live Chat and Phone

Visit fsastore.com/hrctsoe for more information!

$10 OFF

Code:
HRCTSOE

Coupons are valid through 9/30/17. Cannot be combined. 1 use per customer.

Universal Claim Form

Related Case #: ____________

Employee Information

For timely and accurate processing, please complete entire form

Last 4 Digits of SSN (Required)

Phone Number

First Name

Last Name

Plan Year

Email Address

Employer Name

Claims Codes:

F Health Care FSA

L Limited Purpose FSA

H HRA

HF HRA, then FSA

D Dependent Care FSA

AR Apply to Repayment

S Substantiation – Debit Card

P Parking

Enter only one Claim Code per detail section

Claim Code | Start Date of Service | End Date of Service | Provider

Description of Service | Claim Amount

Person Receiving Service (Required for HRA) | Tax ID (Dependent Care FSA only) | Daycare Provider Signature (Dependent Care FSA only)

Claim Code | Start Date of Service | End Date of Service | Provider

Description of Service | Claim Amount

Person Receiving Service (Required for HRA) | Tax ID (Dependent Care FSA only) | Daycare Provider Signature (Dependent Care FSA only)

Claim Code | Date of Service | End Date of Service | Provider

Description of Service | Claim Amount

Person Receiving Service (Required for HRA) | Tax ID (Dependent Care FSA only) | Daycare Provider Signature (Dependent Care FSA only)

Claim Code | Start Date of Service | End Date of Service | Provider

Description of Service | Claim Amount

Person Receiving Service (Required for HRA) | Tax ID (Dependent Care FSA only) | Daycare Provider Signature (Dependent Care FSA only)

Claim Total: $

The above statements and submitted information for reimbursement are true. I am only submitting for reimbursement for eligible expenses that I incurred for myself or legal dependents. I certify that I have not been nor will I be reimbursed for these submitted reimbursements from any other source. I further certify that I will not claim these expenses as a tax deduction.

Employee Signature

Date

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How to Complete Claim Form

1. Complete the Employee Information section. Be sure to include the last 4 digits of your SSN and your email address.
2. Review the Claim Codes.
   Enter Claim Code that corresponds with your plan into the box.
   - **[F]** Health Care FSA Claims
   - **[L]** Limited Purpose FSA
   - **[D]** Dependent Care FSA
   - **[H]** HRA
   - **[HF]** HRA first, then FSA
   - **[S]** Substantiation - Debit Card
   - **[P]** Parking
   - **[AR]** Apply to Repayment
3. Complete the Claims Section.
4. Sign and date the claim form.

Important Notes for Claim Submission

1. Claims will be processed the same day if received by 10:00am EST
2. Please allow 3 business days from the day you submit your claim form before viewing the status on your Participant Portal.
3. Remember to send appropriate claim documentation in with your form to substantiate the expenses you are submitting for reimbursements. Claim documentation m u s t include the provider name, the dates(s) of service, a description of the expenses incurred and the expense amount. **Cancelled checks and non-itemized credit card receipts are not valid forms of documentation**.
4. Retain original copies of the claim form and expense documentation for your files; Claim Forms, receipts and claims information will not be returned.
5. Refer to your company or Summary Plan Description for the length of your run out period, which determines the number of days you have after the plan year ends to submit claims.
6. When submitting claims for your HRA Expenses: please claim the full eligible deductible amount shown on your Explanation of Benefits or receipt. We will automatically make any calculations necessary in accordance with your plan design. You must submit an Explanation of Benefits (EOB) and not a bill from your provider for HRA expenses.

Universal Claim Form

HRC TOTAL SOLUTIONS

Related Case #: ________

1 — **Employee Information**
For timely and accurate processing, please complete entire form

Last 4 Digits of SSN (Required) | Phone Number
First Name | Last Name | Plan Year
Email Address | Employer Name

2 — Claims Codes:
F Health Care FSA | L Limited Purpose FSA | H HRA | HF HRA, then FSA
D Dependent Care FSA | AR Apply to Repayment | S Substantiation – Debit Card | P Parking

Enter only one Claim Code per detail section

3 — Claim Code | Start Date of Service | End Date of Service | Provider | Description of Service | Claim Amount | Person Receiving Service (Required for HRA) | Tax ID (Dependent Care FSA only) | Daycare Provider Signature (Dependent Care FSA only)

Claim Code | Start Date of Service | End Date of Service | Person Receiving Service (Required for HRA) | Description of Service | Claim Amount | Person Receiving Service (Required for HRA) | Tax ID (Dependent Care FSA only) | Daycare Provider Signature (Dependent Care FSA only)

Claim Code | Date of Service | End Date of Service | Provider | Description of Service | Claim Amount | Person Receiving Service (Required for HRA) | Tax ID (Dependent Care FSA only) | Daycare Provider Signature (Dependent Care FSA only)

Claim Code | Start Date of Service | End Date of Service | Provider | Description of Service | Claim Amount | Person Receiving Service (Required for HRA) | Tax ID (Dependent Care FSA only) | Daycare Provider Signature (Dependent Care FSA only)

Claim Total: $

4 — The above statements and submit... ...tion for reimbursement are true. I am only submitting for reimbursement for eligible expenses that I incurred for myself ... dependents. I certify that I have not been nor will I be reimbursed for these submitted reimbursements from any other source. I further certify that I will not claim these expenses as a tax deduction.

Employee Signature | Date

Exchange | HR Outsourcing | COBRA | FSA | DCA | POP | HRA | HSA | PRA | DRA | Commuter | Wellness | Payroll
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Mobile Apps & SMS Text Alerts

Save time and hassles while you make the most of your HSA, HRA, and FSA accounts by checking your balances, submitting a claim, and taking a picture of your receipt on your Android or iOS device. No more losing receipts! Find our mobile app on the Google Play store or on iTunes.

SMS text message alerts are available for all mobile devices on AT&T, Nextel, Sprint, Verizon, and T-Mobile networks! You can opt in/out via the Participant Portal and configure which alerts you prefer to receive.

To submit please send form to:

Customer Service Call Center

Monday – Friday 8:30am-7:30pm ET
Email: customerservice@hrcts.com

Phone: (603) 647-1147 option 1
Fax: (866) 978-7868
Live Chat: http://hrcts.com

Authorization Agreement For Direct Deposits

Employer Name ____

Employee Name ________________________________ Last Four Of SSN#______________

Email Address (Required): ___________________________

I hereby authorize HRC Total Solutions, LLC, hereinafter called HRCTS, to initiate credit entries to my ☐ **Checking** ☐ **Savings** account (select one) indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to credit the same to such account. I further authorize HRCTS, to initiate debits from the aforementioned account indicated below, and to debit the same from such account if an error is made in processing. Processing errors can include a payment that was made via my HRC Total Solutions VISA that was deemed ineligible, or if a forced post puts my flexible spending account with HRC Total Solutions in the negative.

Depository Name: ____________________ City: __________________________ State: ________

Routing #: __________________________ Account #: ______________________

Confirm Routing #: ____________________ *Confirm* Account #: ________________

NAME
ADDRESS
CITY, STATE ZIP

0123
01-2345/6789

DATE ______________

PAY TO THE ORDER OF ____________________ $ [ ]

______________________________ DOLLARS

BANK NAME
ADDRESS
CITY, STATE ZIP

FOR ______________ ______________

0123456780 0123456789D123 0123

Routing Number Account Number

This authorization is to remain in full force and effect until HRC Total Solutions has received written notification from me of its termination in such time and in such manner as to afford HRC Total Solutions and DEPOSITORY a reasonable opportunity to act on it.

DATE: SIGNATURE____

Please return completed form to HRC Total Solutions along with a voided check or savings deposit slip to address below.

NOTE: ALL WRITTEN CREDIT/DEBIT AUTHORIZATIONS MUST PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION. HRC TOTAL SOLUTIONS WILL NOT BE RESPONSIBLE FOR INCORRECT BANKING INFORMATION IF VOIDED DOCUMENTS ARE NOT INCLUDED WITH THIS FORM.

Flexible Spending Accounts Enrollment Form

First Name: ____________________ Last Name: ____________________

SSN: __________ Date of Birth: __________ Street Address: ____________________

City: __________ State: ______ Zip: ________ Phone Number: __________

Additional dependent Visa cards: Recipients must be 18 or older

Name:__________ DOB: __________ SSN: __________ Relationship: __________

Name:__________ DOB: __________ SSN: __________ Relationship: __________

Email Address for All Correspondence: ____________________ 1st Payroll Deduction Date: __________

Company Name: ____________________ EE Effective Date on plan: __________

I authorize my employer to make the following pre-tax reductions from my paycheck according to the elections I have chosen below. These elections cannot be changed until the beginning of the next plan year or if I have a qualifying event; which includes within my immediate dependents, marriage, divorce, death or birth. I will only submit claims for reimbursement or through my VISA that are eligible. If I am reimbursed for a claim that wasn't eligible, I will be responsible for paying the ineligible amount back into the plan through sending payment or having it deducted from my paycheck.

(PLEASE CHECK THE ACCOUNTS YOU WANT TO ENROLL IN AND FILL IN THE AMOUNTS BELOW)

HEALTHCARE FLEXIBLE SPENDING ACCOUNT

☐ **Regular FSA** ☐ **Limited Purpose FSA** (For HSA Participants)

Annual Election for Medical, Dental, and Vision for my family: $ __________

Check the number of pay periods this plan Year: ☐ 52 ☐ 26 ☐ 24 Other: __________

The Amount per Pay Period Reduced from my check for this Account $ __________

(Divide the Annual Election by the Number of Pay Periods Above)

(I understand that my election is based on the eligible expenses allowed by the IRS. Any expense that I have included that is not eligible for reimbursement, will not be paid; any question on eligibility will be determined by my employer.)

☐ DEPENDENT CARE ACCOUNTS

Annual Election for Dependent Care Expenses: $ __________

Check the number of pay periods this plan Year: ☐ 52 ☐ 26 ☐ 24 Other: __________

The Amount per Pay Period Reduced from my check for this Account $ __________

(Divide the Annual Election by the Number of Pay Periods Above)

I understand that my election is based on the eligible expenses allowed by the IRS. These expenses must meet the following requirements:

1. Dependent Care expenses must be incurred during the plan year for the care of a dependent age 12 or younger.
2. Dependent Care expenses may be incurred for a spouse or other tax dependent that is mentally or physically incapable of caring for them self.
3. The expense needs to be incurred during the time that you and your spouse (if applicable) are gainfully employed.
4. The Dependent Care provider must be either a babysitter that cares for the dependent in or outside of your home or a day care center that meets state and local requirements, such as, a pre-school, summer day camp, and after school programs. Any form of dependent care provider you use needs to provide you with a tax ID or social security number.
5. Expense cannot exceed your taxable compensation, or your spouse's actual earned income.

I understand that I cannot change my election during the plan year unless I have a qualifying event and claims must be incurred within the plan year that I'm seeking reimbursement for/form. If I do not utilize all of the monies set aside into this account, then I will forfeit this amount. My social security benefit may be reduced by this election. I will have up to 90 days (or up to the length of time allowed by my employer) beyond the end of the plan year to submit claims that I incurred during the plan year.

Employee Signature: ____________________ Date: __________ Accepted By Employer: ____________________

Please be sure to return this form to your Employer for approval

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Letter of Medical Necessity

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your Healthcare Flexible Spending Account (HFSA), Medical Healthcare Reimbursement Arrangement (HRA), or Health Savings Account (HSA) when your doctor or other licensed healthcare provider certifies that they are medically necessary. A doctor's prescription will be acceptable for reimbursement or you can have your doctor fill out this form for your (or your spouse's or dependent's) specific diagnosis, the specific treatment needed, and the length of treatment. By submitting this Letter of Medical Necessity you certify that the expenses you are claiming are a direct result of the medical condition described below, and you would not incur the expenses you are claiming if you were not treating this medical condition.

You only need to submit this submission form, or your provider's letter containing the same information, with the first claim you submit for the service or product. However, if the treatment extends beyond the time period listed, you must submit a form or physician letter covering the new time period.

Name

Date

Email Address

SSN/User ID

Patient Name

Signature

Diagnosis

CPT Code

Recommended Treatment

Length of Treatment Required

Provider Signature

Provider Name

Provider Address

Provider License #

Provider Telephone #

COPAYMENT RECEIPT

Please use this form to assist in the process of obtaining substantiation for a copayment expense. This form must be completed fully to ensure all necessary information is obtained to substantiate your claim.

Should you have any questions please contact our customer service department: 603-647-1147.

Employee Name: ___________________________________ Email Address:_____________________________________

Mailing Address: __________________________________ City: ___________________ State: _______ Zip: _________

Telephone: _______________________________ Employer Name: ______________________________________

Copayment Details

Date of Service	Name of Provider	Type of Copayment	Copayment Amount

Total of Copayment Amount: $________________

Provider's Office Signature: ____ Date: _______________________

HIPAA Authorization Form

How to File

Form can be submitted by Email, Fax, or Mail

To submit by Email send form to: customerservice@hrcts.com

To submit by Fax print form and send to: (866) 978 – 7868

To submit by Mail print form and send to: HRC Total Solutions 111 Charles St. Manchester NH, 03101

Submitting this authorization form is optional. You do not need to send it unless you want someone else to have access to your Protected Health Information (PHI) such as your spouse, a family member or friend. This means that in order for us to disclose information about you that is not for the purposes of treatment, payment or health care operations, you must first authorize an individual or organization to receive your PHI. This is your choice. Submitting or not submitting this authorization form will not affect your coverage.

Participant's Information

Participant's Name ____________________ SSN or Employee ID# ____________________

Date of Birth ____________________ Type of Account *(FSA, HRA, COBRA, Retiree)* ____________________

Authorized Representative Information

I authorize HRC Total Solutions to use or disclose my protected health information (PHI)

This information may be disclosed to and used by the following individual or organization

Individual's Name ____________________ Organization's Name/Relationship ____________________

☐ Add Authorization ☐ Remove Authorization

Individual's Name ____________________ Organization's Name/Relationship ____________________

☐ Add Authorization ☐ Remove Authorization

Signature

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to HRC Total Solutions. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will commence on the date indicated below and will expire on the following date, event, or condition: ____________________

If I fail to specify an expiration date, event, or condition, this authorization will stay in place until I revoke it.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to obtain coverage. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact this facility's privacy officer.

Signature ____________________ Date ____________________

☐ Self ☐ Parent of Minor ☐ Guardian ☐ Other Authorized Representative (explain):

Signer Identification (check one)

Note: Proof of legal authorization may be required

How to set up an account online:

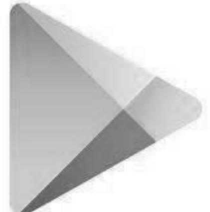
Please go to our Online Account Setup page http://hrcts.com/setup for instructions on retrieving your username, creating an account password, and entering new user security questions to complete your online account profile. **Please note your online account will be available to you **within 30 days** of your plan effective date. If you already have an account you can login directly from https://employee.hrcts.com

Trouble accessing your account?

1. The **Password Length** must be a minimum of 6 characters and is case sensitive.
2. When resetting your password your answers to security questions are case sensitive.
3. **Password History:** Your password must not be one of your last **12 passwords** used.
4. **Account Inactivity:** After **180 days** of inactivity you must follow the password reset process in order to access your account again.

HRC Total Solutions Mobile:

Check your balance, final filing date, submit claims, and upload receipts on any **Android** or **iOS** device. View all claims requiring receipts and submit new receipts by taking a picture with your mobile device.



Google Play Mobile Application

Apple Store Mobile Application

Text Message Alerts:

SMS text message alerts are available for all mobile devices on AT&T, Nextel, Sprint, T-Mobile, Verizon, and Virgin Mobile networks! You can opt in/out via the **Consumer Portal** and configure which alerts you prefer.

- **Claim Confirmation**
- **Claim Denial**
- **HSA Account Summary**
- **Receipt Needed for Debit Card Transactions**
- **Receipt Reminder**
- **Expense Notification**

Automated Phone System (IVR):

- You can now access your Available Balance, Final Filing Date, Final Service Date, Eligible Amount and your most recent transactions all from a **Toll Free** Interactive Voice Response (IVR) phone service!
- This service is available 24x7 to all participants enrolled in an FSA, DCA, HRA, or HSA plan. Just select option 6 when calling HRCTS or you can reach this service directly by calling (877) 415-8093.
- You will need to have a “home” phone on file in your online account along with your zip code in order to use this service.