

**Instructions for Filing
LyfeSystems Medical Expense Funds Transfer Request Form.**

- You may file a Funds Transfer Request (FTR) Form but **ONLY** for Qualified Medical Expenses. A list of many qualified expenses (and what is not qualified) is available online at www.LyfeSystems.com. For more detailed guidance please refer to IRS Publication 502, available at www.irs.gov.
- Required to be submitted with your FTR Form:
 - **For repayment of a bill already paid by you:**
 1. A completed and signed Funds Transfer Request Form
 2. An invoice, bill or receipt showing the name of the person who received the service along with details or summary of services provided. This is necessary so we can determine if it is for eligible medical expenses. A credit card receipt that does not itemize each expense are not sufficient substantiation of services received.
 3. Proof of payment. This can consist of a copy of a canceled check, a credit card receipt, a screen shot of your bank statement showing that the payment has cleared the bank, or a receipt of payment from the provider. This receipt would need to include the name of the provider either stamped or pre-printed on the receipt.
 - **For payment of an outstanding bill:**
 1. A completed and signed Funds Transfer Request Form.
 2. An invoice or bill showing the name of the person who received the service along with details or summary of services provided.
 3. Patient number and/or invoice number along with the mailing address for sending payments.
- Complete all information on the FTR Form for **each medical expense you have paid or for which you seek payment. Please use separate forms for bill payments and repayment requests.**
- The FTR Form must be complete, including employee signature and date. Please complete ALL FIELDS prior to signing.
- Access the Funds Transfer Request Form online by going to www.LyfeSystems.com and selecting “Funds Transfer Request”. Once you have logged in to your account select “Repayment Claims” and then “Repayment Claim Form”. The FTR Form is designed so you can complete it online and then print it out to sign. You can then scan in your form along with the additional documentation needed for documenting a medical expense. Next, click on the “Browse/choose file” button, select the form and upload your document. Include with your FTR Form any scanned copies of your receipts or other documents substantiating your medical expense. Alternatively, you may mail or fax copies of the documents to us. Please keep the original documents for your records and only send LyfeSystems copies.
- We process FTR Forms weekly. Forms received by 12:00pm noon, Pacific Time, Friday, will be processed the following Monday. If that Friday or Monday falls on a holiday, we will process your form the next business day. For **repayments**, if you provide us your checking account information, we can deposit your funds directly to your account. Otherwise, we will mail a check to you. For bill payments, we will send a check directly to the billing address on the invoice.

Where to send a Funds Transfer Request Form if you are not able to file online:

Please fax, mail, or email all FTR Forms to:

LyfeSystems
P.O. Box 697
La Conner, WA 98257
FAX: 360-466-9110
Email: fundstransfer@lyfesystems.com

For any questions regarding a Funds Transfer Request, call (360) 466-9100.

Portable Healthcare (PHA) Funds Transfer Request Form

(This form is to be used for LyfeSystems PHA expenses ONLY)

Employer Name: _____
 LyfeSystems Account #: _____
 Employee Name: _____
 Street Address: _____
 City/State/Zip: _____
 Phone: _____
 E-mail: _____

Select Fund Transfer Type (mark an X in the appropriate box)

Repayment	Direct Pay

Healthcare Expense Report

Date Expense Incurred (mm/dd/yr)	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
Attach appropriate receipt(s) and/or invoice(s) and submit with this FTR form.			Total Medical Expense	

DIRECT DEPOSIT IS AVAILABLE (DOWNLOAD FORM FROM www.LyfeSystems.com)

Read Carefully: The undersigned participant in the plan certifies that all services for which a funds transfer or payment is claimed by submission of this form are qualified medical expenses and have not and will not be paid under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this request which is provided, and that unless an expense for which payment or funds transfer is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the plan which relate to such expense.

Your Portable Healthcare Account (PHA) plan limits the expenses that may be transferred to you as set forth in IRS Code Section 213(d) (including medical insurance premiums, expenses to which your health plan deductible applies, co-insurance, and co-pays). Please read the LyfeSystems account plan summary for your PHA Plan for additional information.

 Employee's Signature
 NOTE: Form MUST be signed to process claim.

 Date

Mail/Fax/Scan FTR Form and Receipts to:
 LyfeSystems
 P. O. Box 697 / La Conner, WA 98257
 Fax: (360) 466-9110 / E-mail: fundstransfer@lyfesystems.com