POST-DEDUCTIBLE FSA CERTIFICATION REQUEST

Voya Benefits Company, LLC
A member of the Voya® family of companies
Customer Service: PO Box 929, Manchester, NH 03105
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Health Savings and Spending Accounts, 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). Administration services provided by WEX Health, Inc. and Benefit Strategies, LLC.

EMPLOYEE INFORMATION

Employee Name *(First)* ______________________________ *(Last)* ______________________________

Social Security Number (SSN) *(Last 4 digits only.)* ______________ Primary Phone (______)______________________

Employer Name ____

Email *(Email is required to receive important account notifications.)* ______________________________

While you incur expenses toward the deductible associated with your HSA qualified medical plan, your Limited Purpose Flexible Spending Account (LP FSA) can only be used for qualified out of pocket dental and vision expenses. Once you have met the current IRS mandated minimum annual HSA deductible for your coverage level (which may be less than your medical plan deductible), the LP FSA can then be transferred to a full FSA by submitting this form. The full FSA can then reimburse not only out of pocket dental and vision expenses but qualified medical expenses as well. This transfer can only be made after meeting the IRS established deductible.

To view a list of FSA eligible expenses and the current IRS mandated minimum annual HSA deductible for your coverage level, visit voya.benstrat.com.

To transfer your Limited Purpose FSA to a full Health FSA, take the following steps:

1. Indicate the date you met the IRS mandated minimum annual HSA deductible for your coverage level: ______________________
2. Attach documentation from your insurance carrier (EOB, Activity Statement, etc.) showing you have met the current IRS minimum HSA deductible amount for your coverage level.
3. Return this form and carrier documentation to Voya Benefits Company, LLC (address, fax and email above).

I certify that on the date I indicated above I met the HSA annual minimum deductible for my coverage level as set by the IRS and have attached documentation from my insurance carrier to prove this. I understand I can only submit medical expenses with a date of service after this date for reimbursement.

Employee Signature *(Required)* ______________________________________ Date ______________

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