



## How to Submit a Claim for Health Savings Accounts

We offer several easy ways for you to access your Health Savings Account (HSA) funds. **For fastest results, we encourage you to submit your claim with myCYC or using your payment card.**

### Payment Card

1. Use your health care payment card to pay for services at eligible health care locations such as doctor's offices, hospitals, and pharmacies. The card deducts the funds directly from your account.
2. Always save your receipts; the IRS may require them at tax time.

### Mobile App Claim Submission

1. Download the [myCYC mobile app](#) from your app store. Log in using your existing ConnectYourCare website username and password.
2. Click "Make a payment" from the main screen. Enter the requested information about your claim and continue through the screens to confirm and submit the claim.

### Online Claim Submission

1. Log in at [www.connectyourcare.com/etf](http://www.connectyourcare.com/etf).
2. Follow the instructions on the main page to enter a new claim. Enter the requested information about your claim and continue through the screens to confirm and submit the claim.

### Paper Claim Submission

1. If you didn't use your payment card and are unable to access the Internet, complete the HSA Withdrawal Form.
2. Fax it to (443) 681-4602
3. If you choose to mail your claim form instead of faxing, the address is:  
**Claims Department**  
P.O. Box 622317  
Orlando, FL 32862-2317



## HSA Withdrawal Form

Use this form to submit your claims for reimbursement of eligible expenses paid out of pocket that have not already been submitted.

- Do not use this form if expenses were already paid with your healthcare payment card.
- Do not use this form if you already submitted this claim online.
- Complete all entries on this submission form. Please print or type.
- Sign and date this form.
- Fax or mail it to the claims department. (See submission instructions below.)

Personal Information	
Name of Employer	Employee ID
Employee Name (last name, first name)	Last Four Digits of Social Security Number

Claim Details					
Date of Service	Patient's Name	Relationship to Employee	Name of Provider	Description of Service	Amount Requested
Total					\$

Authorization and Certification
<p><b><i>Read carefully: This claim will not be processed without your signature.</i></b></p> <p>I understand that I am solely responsible for determining whether or not a distribution from my Health Savings Account is a Qualified Medical Expense as defined by the IRS. I certify that these expenses have been incurred by me, my spouse or my eligible dependent. The expenses have not been reimbursed and are not reimbursable under any other plan, such as an individual policy or my spouse's or dependent's plan. I understand that any amount reimbursed may not be used to claim any federal income tax deduction or credit on my or my spouse's income tax return.</p>
<div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 60%; border-top: 1px solid black; margin-top: 5px;">Signature</div> <div style="width: 35%; border-top: 1px solid black; margin-top: 5px;">Date</div> </div>

Submission Instructions	
Fax to: (443) 681-4602	Or mail to: <b>Claims Department</b> P.O. Box 622317 Orlando, FL 32862-2317
If you have any questions, please contact <b>Customer Service</b> at <b>833-881-8158</b> .	