HRA Claim Request Form

Used to report health reimbursement arrangement claims

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Your claim will not be processed without this form and EOB's

EXPLANATION OF BENEFITS (EOB's) MUST BE ATTACHED

CREDIT CARD RECEIPTS, CANCELLED CHECK COPIES, OR PROVIER INVOICES WILL NOT BE ACCEPTED.

EMPLOYEE INFORMATION

EMPLOYER NAME:	**PLAN YEAR:**
EMPLOYEE NAME LAST:	**FIRST:** **MI:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP:**
DATE OF BIRTH:	**SSN:**
PHONE: ( )	**E-MAIL:**

DEPENDENT INFORMATION
(PLEASE LIST ALL COVERED DEPENDENTS ENROLLED ON YOUR PLAN)

	First Name	Last Name	Date of Birth	SSN
Spouse				
Child				
Child				
Child				
Child				

CLAIMS MUST BE SUBMITTED IN ACCORDANCE POLICY PROVISIONS (E.G., PLAN DOCUMENT, SUMMARY PLAN DESCRIPTION, COMPANY BENEFITS POLICY, ETC.). CLAIMS NOT SUBMITTED IN ACCORDANCE WITH THE RUN-OUT PROVISION MAY BE DENIED FOR UNTIMELY SUBMISSION.

To the best of my knowledge and belief, my statements on this Request for Reimbursement are complete and true. I understand that I am solely responsible for the validity of claims submitted to my Healthcare Reimbursement Arrangement Account. I am claiming reimbursement only for eligible expenses incurred by myself, or any eligible tax dependent(s), and certify that these expenses have not been reimbursed under this Plan or by any other source and that they will not be reimbursed by any other source or insurance. I hereby authorize my HRA Account to be reduced by the amount(s) shown above.

Participant's Signature ____________________ **Date** ____________