Health Reimbursement Arrangement (HRA) Claim Form

EMPLOYEE NAME: LAST | FIRST | MIDDLE INITIAL | COMPANY NAME

LAST FOUR DIGITS OF SOCIAL SECURITY NO. | DAYTIME PHONE NUMBER | EMAIL ADDRESS ❍ check if new

HOME ADDRESS: STREET ❍ check if new | CITY | STATE | ZIP

To the best of my knowledge and belief, my statements for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year for myself and/or my legal dependent(s). I certify that these expenses have not previously been reimbursed, nor will they be reimbursed under any other benefit plan and will not be claimed as an income tax deduction or credit. If there is a discrepancy between the total amount of expenses requested below and the total amount of the attached receipts, I will be reimbursed according to the total amount of eligible expenses on the attached receipts

X

EMPLOYEE SIGNATURE VERIFICATION (Receipts will not be processed without signature) **DATE**

STEP 1: This section of the reimbursement form must be completed only for eligible expenses and only for expenses incurred during your plan year. You must have been a participant in the plan at the time the expense was incurred. The incurred date of the expense is the date of service.

Please thoroughly complete the fields in this section to insure proper reimbursement.
An Explanation of Benefits from your insurance company must be attached.

Explanation of benefits must include the following information:

- ❍ Date of Service
- ❍ Service Performed
- ❍ Provider of Service
- ❍ Amount of Service

- ❍ **Be sure to total your expenses**
- ❍ **Include your explanation of benefits**
- ❍ **Canceled checks/credit card statements are not acceptable forms of documentation**

DATE OF SERVICE	PATIENT NAME	PROVIDER	TYPE OF SERVICE	AMOUNT OF SERVICE
/ /				$.
/ /				$.
/ /				$.
/ /				$.
/ /				$.
			TOTAL HRA EXPENSES	**$.**

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STEP 2: Please fax to 877-767-8804 for the quickest processing time, complete, sign and fax your reimbursement form and all necessary documentation. A cover page is not required. If you prefer to mail your form and receipts, please send to PlanSource, P.O. Box 160940, Altamonte Springs, FL 32714. Please keep all receipts and original documentation as required by the IRS.