

Health Reimbursement Arrangement

Reimbursement Request

Name: \_\_\_\_\_ Employer: \_\_\_\_\_
Street Address 1: \_\_\_\_\_ SS#: \_\_\_\_\_
Street Address 2: \_\_\_\_\_ Phone #: \_\_\_\_\_
City, State, Zip: \_\_\_\_\_ New Address?: [ ] Yes [ ] No

Instructions: Provide information requested below for expenses incurred by you on behalf of yourself, your spouse or your dependents (see the summary plan description for eligible expenses), as applicable. You must provide insurance EOBs, hospital/doctor bills, pharmacy receipts or other applicable evidence from independent third parties that expenses were incurred (canceled checks and/or other statements will not be accepted). Please provide all requested information; an incomplete form will be returned to you.

Unreimbursed Health Care Expenses

Table with 5 columns: Date of Service, Name of Service Provider, Expense Description, Person for Whom Expense Incurred, Net Amount. Includes 8 rows of blank lines for data entry.

Individual Insurance Policy Premiums

Table with 4 columns: Period of Coverage, Name of Provider, Person Covered, Amount Incurred. Includes 3 rows of blank lines for data entry.

To the best of my knowledge and belief, the above information is true and complete. I hereby certify the following: a member of my family has received the services described above on the dates indicated; the expenses are out-of-pocket expenses and qualify as valid health care expenses or individual policy premiums under the plan; these expenses have not been submitted previously for reimbursement under this plan or any other plan, insurance or otherwise, and I will not seek reimbursement for these expenses under any other plan; and, the unreimbursed health care expenses are for medical care (excluding cosmetic purposes), are not incurred for general health purposes and do not constitute toiletries. I understand that the expenses reimbursed may not be used to claim federal income tax deduction or credit. I also understand that I may be asked to provide further detail about some expenses. I hereby authorize the above expenses to be reimbursed from my Health Reimbursement Arrangement account.

Date: \_\_\_\_\_ Employee Signature \_\_\_\_\_

Please fax/send completed form and supporting documentation to: