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Claim for Health Reimbursement Arrangement (HRA) Reimbursement

Please make copies and save for future claims.

Name: ________________________________ **Last Four Digits of SSN:**____________________

Employer: ________________________________ **E-Mail:** ______________________________

Medical Expense Claims to be Reimbursed from your Health Reimbursement Arrangement - HRA

Date Incurred	Name of Service Provider	Expense Description	Person for Whom Expense was Incurred*	Amount Incurred
			TOTAL HRA MEDICAL EXPENSE CLAIMS	$

*Please note that claims can only be submitted for you, your spouse, and dependents. Your Spouse and/or Dependents are those individuals defined as your dependents by the IRS for tax reporting purposes, and your spouse is the person to whom you are married (according to Federal Law) at the end of the year.

READ CAREFULLY

In order to have expenses reimbursed out of your Health Reimbursement Arrangement (HRA) you must provide American Benefits Group with the necessary information showing that the expense is consistent with your company's HRA plan design. For plans that are linked to a group health plan you should provide an Explanation of Benefits (EOB) from your health insurance carrier and the bill from your provider, for non-linked plans that cover Section 213(d) expenses please provide a statement showing; the date the service was incurred, the recipient of the service, the nature of the service provided, the name of the service provider, and the cost of the service. These documents should be mailed or faxed along with this form to the address or fax number below (please make sure this form has been signed and completed).

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's HRA Plan with respect to such expenses, and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for repayment of all such expenses.

Employee's Signature:________________________________ Date:____________________

Fax Toll Free: 866-393-3539 (866-EZE-FLEX) or email to claims@amben.com

(No Fax Machine? Mail to: American Benefits Group, P.O. Box 1209, Northampton, MA 01061-1209)