Flexible Benefit Plan (HRA) Reimbursement Claim Form

Employer _____

Name _____ **Employee ID:** __ __ __ __
(last 4-digits of SSN)

Email Address:_____

Medical Reimbursement Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
		Total Medical Reimbursement Expenses		

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form have been incurred during the period while the undersigned was covered under the Company's Flexible Benefit Plan with respect to such expenses and that the medical expenses have not been reimbursed nor will the participant seek reimbursement for the expenses under any other plan covering health benefits. **The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, 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 payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.**

_____ _____

Employee's Signature **Date** **Daytime Telephone Number**

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