

Health Reimbursement Arrangement (HRA)

Reimbursement Claim Form

Employer Name

Name (Last, First, Middle Initial)

Social Security Number

Address (Street)

E-Mail Address

Address (City, State, Zip) Check Here if New Address

Phone Number (Including Area Code)

Healthcare Expense Claims

Date Expense Incurred (mm/dd/yy)	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
Attach appropriate receipt(s) and submit with this claim form.			Total Healthcare Expense Claim	\$

Read Carefully: The undersigned participant in the plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided 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 alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim that 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 that relate to such expense.

Your Health Reimbursement Arrangement (HRA) plan limits the expenses that may be reimbursed to you to your deductible, co-insurance, and co-pays. Please read the Summary Plan Description for your HRA plan for additional information.

Employee's Signature*

Date

*Note: Form must be signed in order to process the claim.

Instructions for Filing a Claim

- Complete all information on the claim form for each amount claimed for reimbursement
- Make sure the claim does not include items for more than one plan year. Use different claim forms for different years.
- Attach copy of a bill, invoice, or other written statement from a third party (such as an Explanation of Benefits (EOB)) that supports each reimbursement request and shows the date the service was incurred.

Claim Form

- If you **mail** your claim with EOB's or receipts, remember to keep a copy of the claim form and supporting documents for your records
- If you **FAX** your claim with EOB's or receipts, please remember to keep the original claim form and supporting documents for your records.

Where to Send a Claim

Mail to:

Attn: Flex Claim Reimbursement
Nyhart
8415 Allison Pointe Boulevard, Suite 300
Indianapolis, Indiana 46250-4205

For any questions regarding a claim, call:

Nyhart
Indianapolis: 317-845-FLEX (3539)
Toll-Free: 800-284-8412
Fax: 888-887-9961

or Send E-mail to:

flexplans@nyhart.com