Reimbursement Claim Form – HRA FORM

GROUP NAME/GROUP # _____

Name: _____ Social Security #: _____ Phone #: _____

Address: _____ City, State, Zip: _____

New Address? ☐ Yes ☐ No Email Address: _____

Health Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
		Total Health Expense Claim:		

Read Carefully:

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 time period while the undersigned was covered under the Company's Flexible Spending Accounts 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/she alone is fully responsible for the sufficiency, accuracy, and veracity of all the 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.

To request reimbursement of a medical, dental or vision expense, you must complete this form and **attach an Explanation of Benefits (EOB)** that clearly indicates: (a) that the expense has been incurred; (b) the amount of the expense; and (c) that the expense has not been reimbursed or is not reimbursable under **any** other health plan coverage. If you and/or your dependents are covered by more than one health plan, you must submit an EOB from *both* plans along with this completed form.

If an EOB is not available (for example: over the counter drugs reimbursable under the FSA or possibly a claim for a service for which you are not insured), please submit a receipt that shows the expense and date of service along with proof of payment.

Dependent Care Expense Claims

Name of Dependent(s)	Period Covered From:	To:	Name, Address, and Taxpayer Identification Number of Provider of Service	Net Amount

Note: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. (If your spouse if either a full-time student or is incapable of taking care of himself/herself, then he/she is deemed to have monthly earnings of $250 if there is one [1] child or dependent, and $500 if there are two [2] or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes, or is your child/stepchild under age 19.

Employee's Signature: _____ Date: _____

You may copy this form if additional claim forms are needed.

Fax or mail to: (412) 922-3071

90 Degree Benefits, Inc., Manor Oak Two, Suite 605, 1910 Cochran Road, Pittsburgh, PA 15220 ATTN: Flex Dept.

Need more forms? Telephone us at (800) 922-4966 or (412) 922-2803