Health Reimbursement Arrangement (HRA)
Reimbursement Claim Form

Employer: _____

Employee Name: _____ Social Security Number: _____

HRA 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 this claim form		**Total HRA Expense Claims**		**$**

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 Health Reimbursement Arrangement 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 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.

Your Health Reimbursement Arrangement (HRA) Plan may be limited to the types of healthcare expenses that may be reimbursed to you. Please read the Summary Plan Description for your HRA Plan for a list of eligible expenses.

Employee Signature_____ Date: _____

Compensation Consultants, Ltd.
P.O. Box 720
Cloquet, MN 55720-0720

Fax: 1-218-879-9684 ❖ Ph: 1-800-447-1690 ❖ flex@cpinternet.com
WWW.CCFLEX.COM

*claim forms are also available for printing at this web site