AMERICAN BENEFITS GROUP

RMSA CLAIM FOR REIMBURSEMENT

Participant's Name: _____ Last Four Digits of SNN: _____

Participant's Address: _____ Change? ☐ yes ☐ no

Phone Number: _____ Email Address: _____ Change? ☐ yes ☐ no

Former Employer: _____

Unreimbursed Medical Expense Claims

	Date Expense Incurred (Dates of Service)	Name of Service Provider	Detailed Description of Expense	Person for Whom Expense was Incurred (Self, Spouse, etc.)*	Expense Amount Claimed
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
				Total Claims	

* Claims can only be submitted for covered individuals.
Please refer to your HRA Plan Document to determine who qualifies as a covered individual.

READ CAREFULLY

In order to have expenses reimbursed from your Retiree Medical Savings Account (RMSA), you must provide American Benefits Group with the IRS required substantiation to verify that the expense is a covered, unreimbursed medical, dental or vision expense as defined under IRC Section 213(d). **The substantiation must state the medical services or items received, and the cost paid by you. It must also show the dates of service, the provider's name and the recipient's name.** 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 completed and signed.

The undersigned participant in the plan certifies that all expenses being submitted for reimbursement on this claim form were incurred during a period when the undersigned was covered under the Company's RMSA Plan. In addition the undersigned certifies that the medical expenses have not been previously reimbursed and are not reimbursable under any other health plan coverage. The undersigned acknowledges that he or she is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim, and that, the undersigned may be liable for repayment of any and all improperly claimed expenses.

Participant Signature: _____ Date: _____

Please submit this claim form along with substantiating statements of services received.

Fax: 877-723-0147 • Email: RMSAclaims@amben.com
Mail: American Benefits Group • RMSA Claims • PO Box 1209, Northampton, MA 01061-1209
Tel: 855-482-5246 (855-48-CLAIM)