AMERICAN BENEFITS GROUP

REPRODUCTIVE HEALTH HRA – REIMBURSEMENT REQUEST

Please make copies and save for future claims filing

Name: _____ Last Four Digits of SSN: _____

Employer: _____ Email: _____

Expense Description	Date of Expense	Name of Service Provider / Vendor	Amount
		TOTAL CLAIM	$

Medical Services related but not limited to the following fertility services:

- Any cost to for treatment of a medical condition, including most physician visits, medications, and medical procedures.
- Artificial insemination, in vitro fertilization (IVF), and the temporary storage of eggs and/or sperm are deductible medical expenses.
- Surgeries relating to fertility treatments are recognized by the IRS as a medical expense, as well as surgeries to reverse a prior surgery that has impacted a person's ability to procreate.
- Acupuncture treatments to increase fertility.
- Counseling costs related to fertility treatment.
- Travel, including mileage and lodging, to obtain fertility treatment (The IRS recommends tracking the mileage in a logbook that contains the dates and purposes of each visit).
- For more information on deductible medical expenses see IRS Publication 502.

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 period while the undersigned was covered under the HRA plan with respect to such expenses and that the HRA expenses have not been reimbursed and will not be reimbursed under any other benefit plan. The undersigned fully understands that the 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 relates to such expense.

Employee's Signature: _____ Date: _____

Please submit this claim form along with receipts. *Receipts should indicate the dates of service, the name of the provider, nature of service, and the cost of the service.*

Fax Toll Free: 877-723-0147

Submit claims in your secure WealthCare portal www.amben.com/wealthcare

Securely email to claims@amben.com