AMERICAN BENEFITS GROUP

# HEALTH REIMBURSEMENT ARRANGEMENT (HRA) – CLAIM FORM

*Please make copies and save for future claims filing*

Name: _____ Last Four Digits of SSN: _____

Employer: _____ Email: _____

## Expense Claims *(for you and/or your eligible dependents)*

| Date Incurred | Name of Service Provider | Expense Description | Person for Whom Expense was Incurred* | Amount Incurred |
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| | | | 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 out of your Health Reimbursement Arrangement (HRA) you must provide American Benefits Group with the necessary information showing that the expense is consistent with your company's HRA plan design. For plans that are linked to a group health plan you should provide an Explanation of Benefits (EOB) from your health insurance carrier and the bill from your provider, for non-linked plans that cover Section 213(d) expenses please provide a statement showing; the date the service was incurred, the recipient of the service, the nature of the service provided, the name of the service provider, and the cost of the service. 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 signed and completed).**

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 HRA Plan. In addition the undersigned certifies 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 is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim 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 repayment of all such expenses.

Employee's Signature: _____ Date: _____

Please submit this claim form along with substantiating receipts or statements.

*(Receipts must indicate the dates of service, the name of the provider, the nature of the service rendered or product purchased, the person for whom the service was provided and the cost of the service)*

**Fax Toll Free: 877-723-0147 or email to claims@amben.com**

No Fax Machine? Mail to: American Benefits Group •
PO Box 1209, Northampton, MA 01061-1209 • 800-499-3539