Mail or Fax to: EBPA Reimbursement Accounts (HRA)
P.O. Box 1140
Exeter, NH 03833-1140
Fax: 603-773-4415
Phone: 888-678-3457

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) FORM

NAME	SOCIAL SECURITY NUMBER (OPTIONAL)
ADDRESS (STREET)	EMPLOYER
ADDRESS (CITY, STATE, ZIP CODE)	

EXPENSE FOR:		DATES OF SERVICE:		TOTAL BILL (ATTACH COPY OF EOB)	AMOUNT APPLIED TOWARD DEDUCTIBLE	AMOUNT OF REIMBURSEMENT DUE
FIRST NAME	RELATIONSHIP	FROM	TO			
TOTAL DUE EMPLOYEE:						

PLEASE PROVIDE DOCUMENTATION OF YOUR EXPENSES WITH THIS CLAIM FORM. A COPY OF THE "EXPLANATION OF BENEFITS" FROM YOUR INSURANCE COMPANY OR AN ITEMIZED RECEIPT IS REQUIRED.

I certify that the above listed expenses have been incurred by me, my tax dependents, and/or spouse (if filing taxes jointly). I further understand that expenses reimbursed by an HRA may not be reimbursed by a Flexible Spending Account (FSA) or claimed on my individual tax return at the end of the year.

Employee Signature: _____ Date: _____