benefit strategies LLC
SAS 70 Certified

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) REQUEST FORM

FAX CLAIMS TO: (603) 647-4668
CLAIM SUPPORT: (603) 647-4666 or (888) 401-FLEX
EMAIL CLAIM SUPPORT: claimsupport@benstrat.com
MAIL TO: PO Box 1300, Manchester, NH 03105-1300
ONLINE ACCOUNT: http://www.benstrat.com

Name: ______________________ Company: ______________________

Home Mailing Address: Check if NEW ☐ Social Security Number: ______________________

Address: ______________________ Plan Year: __________ -to- __________

City: __________ State: ______ Zip: ______ Telephone: *Home:* (   ) __________

E-mail: ______________________ *Daytime Phone:* (   ) __________

INSTRUCTIONS / REMINDERS

1. Be sure to attach a **COPY** of the itemized receipt(s), or if you have insurance, please send the Explanation of Benefits Statement. **KEEP** original receipts for your tax records.
2. **Complete** claims received by NOON on Thursday will be generally processed on Friday.
3. The **participant** must **sign** claim form.
4. *Incomplete forms or unsigned forms* will be **returned** to the participant and **not** processed
5. Reimbursement requests should be for a minimum of **$25** (unless using remaining account balance)

Health Reimbursement Arrangement documentation may include statements, itemized bills, and/or insurance "Explanation of Benefits" forms. All documentation must show:

1. The date the expense was **incurred** (not the date paid).
2. The provider of services.
3. A description of the service and/or expense.
4. The amount of the expense for which you are responsible.
5. Note: Cancelled checks, credit card receipts, and balance forward statements are NOT acceptable documentation

PARTICIPANT STATEMENT & SIGNATURE (Required)

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for IRS eligible expenses incurred by my ***legal*** dependents or myself (Domestic/Civil Union Partners are not IRS eligible dependents in most cases). I certify that these expenses have not been and will not be reimbursed from any other source and will not be claimed as an income tax deduction.

PARTICIPANT SIGNATURE (REQUIRED) ______________________ DATE: __________

HEALTH REIMBURSEMENT ARRANGEMENT EXPENSES REQUESTING REIMBURSEMENT Use second sheet if needed.

Amount to be Reimbursed	Service Date(s)	**Description** *(Not all plans allow all descriptions listed below please refer to your summary plan description for details on your plan)*	Person receiving product / service
$		☐ Deductible ☐ Inpatient Services ☐ Medical ☐ Coinsurance ☐ Outpatient Services ☐ Prescription ☐ Other (please describe):__________	
$		☐ Deductible ☐ Inpatient Services ☐ Medical ☐ Coinsurance ☐ Outpatient Services ☐ Prescription ☐ Other (please describe):__________	
$		☐ Deductible ☐ Inpatient Services ☐ Medical ☐ Coinsurance ☐ Outpatient Services ☐ Prescription ☐ Other (please describe):__________	
$		☐ Deductible ☐ Inpatient Services ☐ Medical ☐ Coinsurance ☐ Outpatient Services ☐ Prescription ☐ Other (please describe):__________	
$		☐ Deductible ☐ Inpatient Services ☐ Medical ☐ Coinsurance ☐ Outpatient Services ☐ Prescription ☐ Other (please describe):__________	
$		☐ Deductible ☐ Inpatient Services ☐ Medical ☐ Coinsurance ☐ Outpatient Services ☐ Prescription ☐ Other (please describe):__________	

$__________ **TOTAL Health Reimbursement Requested** include second page total (Payments are made directly to the employee.)