☐ I will pick up my check - **BRING ID**

HEALTH REIMBURSEMENT ACCOUNT (HRA) CLAIM FORM

EMPLOYEE NAME	LAST 4 DIGITS OF EMPLOYEE SOCIAL SECURITY #	EMPLOYER NAME
PLEASE CHECK IF NEW ADDRESS ☐	DAYTIME PHONE #	YOUR EMAIL

HOME ADDRESS	CITY	STATE	ZIP

PLEASE SIGN BELOW

To the best of my knowledge and belief, my statements in this Claim Form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this plan, an HSA, or any other benefit plan and will not be claimed as an income tax deduction, nor will I seek reimbursement from any other source.

Employee's Signature _____ Date_____

Instructions for Submission of Claim Requests

1) Complete the information requested above.

2) Sign and date this form.

3) Attach a copy of the Explanation of Benefits (EOB) report from your medical insurance company.

4) For prescriptions, attach the receipt that includes patient name, medication name, date and amount owed.

5) Mail, fax or scan/email this form and your receipts.

Total Pages Sent _____

Total Reimbursement Expected _____

- ✓ **Mail** **FlexBank Administrators, 1250 W. Dorothy Lane, Suite 107, Dayton OH 45409**
- ✓ **Fax** **937.299.7992 or 888.677.9373**
- ✓ **Email** **Claims@FlexBank.net**

Questions? Call us 888.677.8373 or visit our website www.flexbank.net.

THIS IS YOUR COVER SHEET FOR FAXED CLAIMS