
Health Care Expenses: Fill out this section if you are requesting reimbursement for a Medical, Dental or Prescription expense, as allowed by your plan:				
	(deductible, dental, medical, orthodontia, OTC, RX, vision)	(not payment date) MM/DD/YYYY	(not payment date) MM/DD/YYYY	
				$
				$
				$
				$
				$
	Attach the supporting documentation for each claim.			

For your first request for reimbursement, include a copy of the statement you received that shows your premium is being deducted from your Social Security check. We will keep this on file for the remainder of the calendar year. After that first request, all you'll need to do is resend this claim form monthly to receive your reimbursement.

For lost documents, you can contact the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778).

Each month and as allowed by your plan send a copy of the statement from the insurance company showing your premiums, the covered individual's name, type of coverage, dates of coverage and proof of payment along with this claim form

: Premiums that you pay pre-tax are not eligible expenses.

If you are requesting Premium Reimbursement, fill out this section:					
	(Medicare Part B, Medicare Part C, Medicare Part D (Prescription Drug), Dental, Medigap, etc.)		MM/DD/YYYY	MM/DD/YYYY	
		☐ Yes ☐ No			$
		☐ Yes ☐ No			$
		☐ Yes ☐ No			$
		☐ Yes ☐ No			$
		☐ Yes ☐ No			$
	Attach the supporting documentation for each claim.				

I understand that an Internal Revenue Service (IRS) rule only lets me use my HRA for eligible individuals if they're covered by a compliant group health plan*. I certify that the patient noted on my claim (myself, spouse, or eligible dependent) is covered under my Employer's group health plan or another compliant group health plan*. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions. *The group health plan must be compliant with the Affordable Care Act (ACA). It can't have annual or lifetime dollar limits on essential health benefits. And it can't exclude coverage because of pre-existing conditions.

I certify that my spouse, eligible dependent or I have incurred each expense on this form. These expenses are for eligible medical care. The expense is not for cosmetic purposes. I understand that "incurred" means that the service has been provided. It does not mean when I am billed, charged or pay for the medical care. I have not received reimbursement for these expenses. I will not seek reimbursement elsewhere, including from a Health Savings Account (HSA).

