



HRA Reimbursement Request

PLEASE PRINT CLEARLY

CROSBY BENEFIT SYSTEMS, INC.

Employee Information

To update your address or email, please login to MyCrosbyBenefits.com

Please also notify employer of any address changes.

Employee Name _____ SSN _____
Last First MI

Employer _____ Employee ID (if known) _____

Home Address _____
Street City State Zip

Email Address _____

Home Phone (_____) _____ Work Phone (_____) _____
area code area code ext.

Spouse and Dependent Information

If expenses for reimbursement are for your spouse or dependent children, please complete this section.

NOTE: Your spouse is the person to whom you are married (according to Federal Law) at the end of the year. Your Spouse and/or dependents are those individuals defined as your dependents by the IRS for tax reporting purposes.

Dependent's Name	Date of Birth	Relationship to Employee
_____	_____	_____
_____	_____	_____

Expenses

Please list the allowable expenses and include the EOB statement stating the partial payment of the expense.

Description of Expense	Date of Service	Amount*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*Do not include amounts paid or eligible for payment under any other health care plan or program, federal, state or governmental program, Workers' Compensation, or any other policy of health insurance.

TOTAL EXPENSES \$ _____

Submit EOB statements with this form, showing the service or product provided, to whom, by whom, the date and the out-of-pocket expense. Retain a copy for your records. Canceled checks are NOT acceptable. Neglecting to submit required documentation may delay claims processing.

Employee Certification

By submitting this form, I hereby certify that all items submitted for reimbursement under the HRA plan comply with the Reimbursement Plan rules and such items have not and will not be covered by any other plan of any employer or any other person. I further certify that such items will not be deducted or taken as tax credits on my personal federal and/or state income tax return for any year. My employer does not accept responsibility for direct payment to any individuals other than the employee. I have read and understand the information on the reverse side (or page 2) of this form.

Please SIGN

I have read and understand both the information on the reverse side (or page 2) of this form and the fact that I can request a copy of the SPD from the Employer if I do not currently have a copy.

Employee Signature _____ Date _____



IMPORTANT INFORMATION

HRA – Health Reimbursement Arrangement Eligible Expenses

To file a request for reimbursement from your HRA: 1. Complete an HRA Reimbursement request form. 2. Attach the Explanation of Benefits (EOB) statement. Your proof for medical expenses must clearly indicate:

1. The person receiving the service
2. The type of service or supply
3. The name of the person providing the service or supply
4. The amount charged
5. The date the service was rendered.

Submission of Reimbursement Requests

Fax (preferred), email or mail reimbursement requests. If your reimbursement request is denied, written notification will be mailed to you. You may resubmit expenses with proper documentation, if applicable. Expenses are to be submitted to Crosby Benefit Systems, using the HRA Reimbursement Request Form.

Please Note

Service dates for reimbursable expenses must fall within the plan year. Participants who leave the plan during the plan year will only be reimbursed for expenses incurred while they were participating in the plan. Expenses incurred before participation began or after participation has terminated will not be reimbursed. After enrollment, changes to a reimbursement account may only occur when there has been a qualified change in status. Reimbursement requests not submitted during the plan year must be submitted/received (pursuant to plan rules) and approved prior to the end of the run out period. Contact your Human Resources Department or Crosby Benefit Systems for more information.