Health Reimbursement Arrangement Claim Form

Employer Name ______________________________

Name	
Home Address, City, State, Zip Code	
Social Security # (Last 4 Digits)	Daytime Phone Number

Date Expense Incurred	Name of Provider	Expense Description	Person for Whom Expense Incurred	Amount

I certify that the expenses being submitted were incurred while covered under the Company's Health Reimbursement Plan, and have not been reimbursed by any other source. If the claim is not valid, I recognize that I will be liable for payment of all taxes on amounts paid form the Plan which relate to that expense. I also recognize that I cannot claim these expenses on my personal income tax return.

Employee Signature	Date

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Rev. 8/14