

Health Reimbursement Arrangement Claim Form

Employer Name _____

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

Date of Explanation of Benefits Form	Deductible Amount (s)

Please attach a copy of your Explanation of Benefits Form for all claim amounts listed above.

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 from 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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