Employer Name: _____
HRA Claim Reimbursement Form

Last Name	First Name	Middle Initial	Social Security No.
Home Address			Daytime Phone
City		State	Zip

Medical Expense Claims

Date of Explanation of Benefits Form	Amount

Prescription Drug Expense Claims

Date of Prescription Drug Purchase	Amount

Dental Expense Claims

Date of Explanation of Benefits Form	Amount

Vision Expense Claims

Date of Prescription Drug Purchase	Amount

Please attach your Explanation of Benefits Form and/or prescription drug receipts to this claim form.

I certify that the expenses being submitted were incurred while covered under the Company's Health Reimbursement Arrangement, 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 _____

Send completed reimbursement form and receipts to

THE HARRISON GROUP, INC.
3 Raymond Drive, Suite 201 · Havertown, PA 19083 · 610-853-9075 · Fax 610-853-9079
Email service@theharrisongrouponline.com