Universal Claim Reimbursement Form

Today's Date: _____ Plan year beginning for: 20_____ Number of pages: _____

☐ New Claim	☐ Resubmission of claim	☐ Response to claim denial
Employer Name (Do not abbreviate)		
Employee Full Name		**Social Security No. (last 4 digits)**
Employee Mailing Address		**City/State/Zip**
Email Address		**Mobile Phone**

☐ Check here if change of information above.

Reimbursement Request from Account:

☐ Healthcare Flexible Spending Account

☐ Limited Purpose Flexible Spending Account

☐ Dependent Daycare Flexible Spending Account

☐ Mass Transit Commuter Benefits Account

☐ Health Reimbursement Account (HRA)

☐ Parking Commuter Benefits Account

Please use a separate form when requesting reimbursement from different accounts.

Name of Person Who Incurred Expense	Amount Requested	Date(s) of Service	Type of Service
Total Amount Requested:	$ 0.00		

I certify that the expenses being submitted were incurred while covered under the Company's pre-taxable benefit accounts and have not been reimbursed by any other source. If the claim is not valid, I recognize that I will be required to repay any expense amounts that are incorrectly reimbursed. I also recognize that I cannot claim these expenses on my personal income tax return.

Employee Signature _____ Date _____

Send completed reimbursement form and attach Explanation of Benefits (EOB) and/or receipts to:

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