Health Reimbursement Arrangement (HRA)
Enrollment Form

Participant Information			
Employer Name (Do not abbreviate)			
Last Name	First Name	Initial	Social Security Number
Street Mailing Address			Mobile Number
City, State, Zip Code			Date of Birth
Email Address			Hire Date

Spouse and Dependent Information	Date of Birth	Social Security Number
Spouse Name:		
Dependent Name:		
Dependent Name:		
Dependent Name:		
Dependent Name:		

Employee Signature _____ **Date** _____

Employer Authorization	
Benefit Effective Date:	HRA Contribution Amount:
Benefit/HRA Plan Name	
Employer Representative: _____ Date: _____	

HRA USER GUIDE 2025-26

WWW.THEHARRISONGROUPONLINE.COM

Welcome to The Harrison Group!

We're so happy to help you with your **HEALTH REIMBURSEMENT ARRANGEMENT (HRA)**.

This guide will explain how you can log in to see your account activity, as well as information on how to utilize your HRA.

Additional resources may be found on our website at:
www.theharrisongrouponline.com

2025

Managing your accounts has never been easier!

LOGGING IN TO YOUR PARTICIPANT WEB PORTAL

- Open your browser and search **www.theharrisongrouponline.com**
- Select "I am a Participant" on the main page
- Go to "Participant Log In"
- Enter your User ID and Password

Your USER ID is the first letter of your first name, your last name, then the last four digits of your Social Security Number.

Your PASSWORD is the last four digits of your Social Security Number.

Upon logging in, you'll be prompted to create a new password. The password must have at least 6 characters including: 1 uppercase letter, 1 lowercase letter, and 1 number.

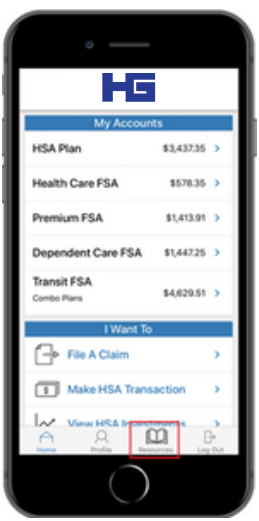
When you log in, you'll have access to several features including:

✓account balance information
✓reimbursement requests
✓securely upload claim documentation

Save time and hassle with an easy to use convenient Mobile App.

MOBILE APP

- Open the App Store or Google Play on your mobile device.
- Search **"Harrison Group FSA HRA HSA".**
- Download the free Harrison Group app and open it.
- Enter your login information (refer to page 3).



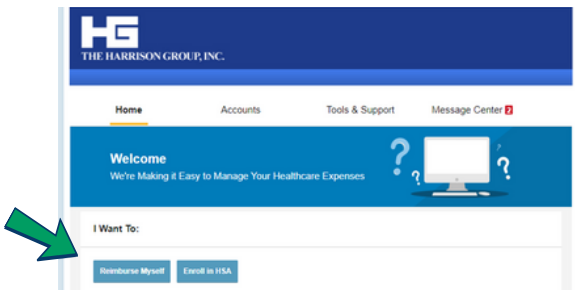
✓check your account balance(s)
✓upload receipts and file a claims
✓scan barcodes to see if items are 213d eligible, if applicable to your HRA.

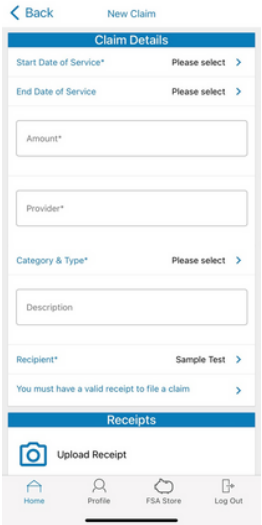
unique to you | tested & trusted | easy navigation | user feedback

You can submit a claim form in order to be reimbursed from your HRA.

CLAIM FORM SUBMISSION

You can process an ELECTRONIC CLAIM SUBMISSION via your Online Portal or Mobile App





- Log in to your Online Portal (or) Mobile App.
- Click the button “Reimburse Myself”.
- Follow the screen prompts to submit claim information and a copy of the Explanation of Benefits (EOB) or receipt.

PAPER CLAIM FORM SUBMISSION

- Complete a claim form with specific information about the expense including date of service/expense, amount, and description.
- Email, fax, mail, or electronically upload your claim form with the receipt or Explanation of Benefits (EOB).
- Claims processed regularly.
- Reimbursements made via direct deposit or check via US mail.
- Claim forms may be downloaded here.

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 _____

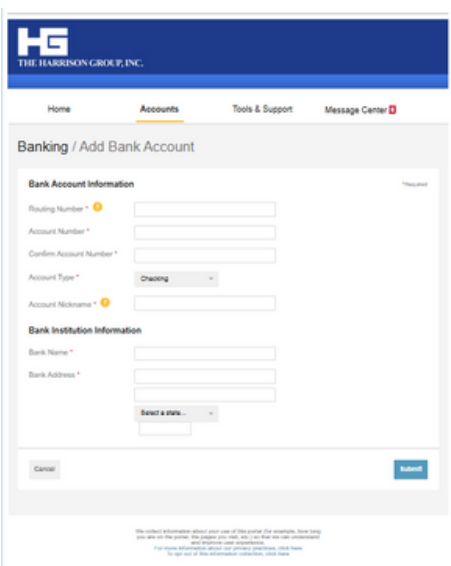
Send completed reimbursement form and attach Explanation of Benefits (EOB) and/or receipts to:

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

The fastest way to get your money when submitting a manual claim is to sign up online for direct deposit.

SETTING UP DIRECT DEPOSIT

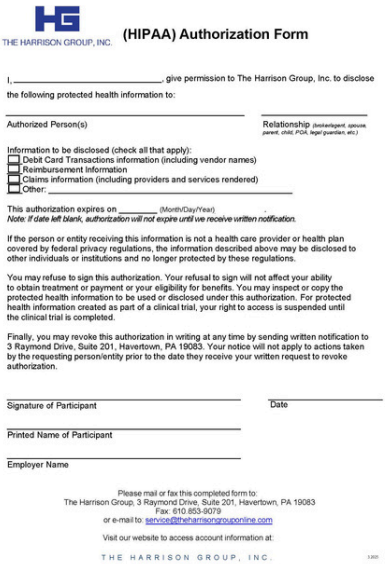
- Log in to your Participant Portal.
- From the Home Page, under the “Accounts” tab, click “Banking/Cards.”
- Enter your bank account information and click Submit.
- The “Payment Method Changed” confirmation displays.
- In some cases, you will be notified on the portal to look for a small transaction or “micro-deposit” in your designated bank account in the next couple of days to enter online, which will validate your account.
- Once received, log back into the Participant Portal to validate your bank account.



Would you like for your spouse or another person to have access to your account or information?

GRANTING HIPAA PERMISSION

- Log in to your Participant Portal.
- From the Home Page, under the Tools & Support tab, navigate to the “Documents & Forms” section.
- Select the “HIPAA Authorization Form”.
- Download the form to your computer and print out.
- Send the completed form to us via email, fax, or mail.
- Your HIPAA authorization will be in effect until authorization revoked in writing.



THE HARRISON GROUP, INC.

(HIPAA) Authorization Form

I, _____, give permission to The Harrison Group, Inc. to disclose the following protected health information to:

_____ _____
Authorized Person(s) Relationship *(brother/sergeant, spouse, parent, child, POA, legal guardian, etc.)*

Information to be disclosed (check all that apply):
- ☐ Debit Card Transactions information (including vendor names)
- ☐ Reimbursement Information
- ☐ Claims information (including providers and services rendered)
- ☐ Other: _____

This authorization expires on _____ (Month/Day/Year)
Note: If date left blank, authorization will not expire until we receive written notification.

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending written notification to 3 Raymond Drive, Suite 201, Havertown, PA 19083. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

_____ _____
Signature of Participant Date

_____
Printed Name of Participant

_____
Employer Name

Please mail or fax this completed form to:
The Harrison Group, 3 Raymond Drive, Suite 201, Havertown, PA 19083
Fax: 610.853-9079
or e-mail to: service@theharrisongrouponline.com

Visit our website to access account information at:

THE HARRISON GROUP, INC.

QUESTIONS?

Our account managers are available to answer any questions you may have throughout the year. We strive to deliver flawless customer service to make your life easier. Whether you utilize our website, participant portal, mobile app, or call and email us, we will answer your questions promptly and with our best customer care.

610.853.9075 Phone
855.222.5727 Toll Free
Email: service@theharrisongrouponline.com
Web: www.theharrisongrouponline.com

THE HARRISON GROUP, INC.

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**

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