

HEALTH REIMBURSEMENT CLAIM FORM

Employee Name: _____

Home Phone: _____

To receive reimbursement for eligible expenses incurred during the plan year, bring this completed and **signed** claim form, along with IRS-required documentation of the expense from an independent third party (such as receipt), which must include all of the following:

- Date of purchase
- Name of provider
- Amount charged

CANCELLED CHECKS DO NOT QUALIFY AS THIRD-PARTY DOCUMENTATION AND ARE NOT ACCEPTED BY THE IRS

Health Care Expense Reimbursement (HRA/Employer Funded)

Date of Service	Amount Paid	Amount to be Reimbursed (Office Use Only)
	Total	

I hereby certify that all the medical expenses on this reimbursement form have been incurred by me, my spouse and/or my eligible dependents during the plan year and qualify for reimbursement. I understand that the medical expenses are deemed to have been "incurred" when the services giving rise to the claim are rendered, regardless of when I am formally billed, charged or pay for the service. I certify the expenses are medical expenses as defined in Section 213(d) of the Internal Revenue Code of 1986, and are not for cosmetics, cosmetic surgery, premiums on accident or health insurance or coverage for long-term care services. I certify that these expenses have not been or will not be reimbursed under this or any other benefit plan. I also understand that any reimbursed expenses cannot be used to claim a deduction or credit on my personal income tax return. This is not a guarantee that the payment is tax free if the requested items do not meet IRS rules.

Employee Signature: _____ Date: _____