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HEALTH REIMBURSEMENT ARRANGEMENT CLAIM FORM

Send This Completed Form To:
The Employee Benefit Service Center
P.O. Box 1803
Dublin, Ohio 43017
Phone: 800-310-6645
Facsimile: 844-328-5824

_____
EMPLOYER

_____
EMPLOYEE NAME

_____
EMPLOYEE ADDRESS (NUMBER, STREET, CITY, ZIP CODE)

_____ _____ _____
EMPLOYEE SOCIAL NO. EMPLOYEE DATE OF BIRTH EMPLOYEE PHONE NO.

I request reimbursement from the funds available in my Health Reimbursement Arrangement. The services are qualified under the Plan and itemized below with my receipts or with my Explanation of Benefits from the Accident And Health Plan.

Patient Name	Relationship	Dates Of Service	Description Of Service(s)	$ Expense

I certify that I have not requested reimbursement under this Plan or from any other source for the above expenses. I understand that I cannot claim expenses reimbursed under this Plan on my personal income tax return. I agree to reimburse the company for any liability that may incur for failure to withhold income tax or Social Security tax because of a non-qualifying reimbursement paid to me as a result of incorrect information provided by me.

I acknowledge that the expense(s) has (have) been incurred as substantiated by the attached documentation and that they have not been, or will not be, reimbursed by any other health Plan or other program.

Employee Signature_____ **Date**_____

Please file expenses covered by your medical, dental, or other plan with that employee benefit plan before requesting reimbursement through this plan.

Please attach the Explanation of Benefits or receipts including name of service provider, date of service, detail of service and amount that you paid for the service

Filing Of Claims For The Health Reimbursement Arrangement

(Back of Health Reimbursement Arrangement Claim Form)

This Claim Form is to provide an easy mechanism to file for unreimbursed medical expenses under your Health Reimbursement Arrangement. To reimburse you for your medical expenses, we need:

1. A completed Claim Form (other side), and,

2. A receipt for each claim stamped paid by the medical providers office and listing the patient name, physician name, charge and date of service,

OR,

3. A copy of the Explanation of Benefits provided by an insured or self-funded medical plan.

We will complete reimbursement checks twice monthly and pay you directly. We will not pay the medical providers directly. It is your responsibility to pay your medical care providers directly for services not covered by the Accident And Health Plan. It is important to complete all information on the form and attach receipts with the above information.

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E-Mail: customer.service@ebscenter.com

Covered Medical Care Expenses

Please see your Summary Plan Description For A Listing Of Covered Expenses.