HEALTH REIMBURSEMENT ARRANGEMENT PLAN (HRA)
Claim Form

Company: _____ Employee Name: _____

This claim form is to be used only to request reimbursement from your Health Reimbursement Arrangement (HRA) for health care expenses. When requesting reimbursement, your explanation of benefits or other receipts allowed by your specific Plan showing that you incurred this expense, must be submitted with this claim form.

IN ALL CASES, YOU MUST SIGN THE BOTTOM OF THIS FORM

Date Expense Incurred	Name of Service Provider	Expense Description	Relation to Person for Whom Expense Incurred (i.e. self, child, spouse)	Amount
			Total	

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the HRA Plan. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned and that unless an expense for which payment or reimbursement is claimed as a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned fully understands that no medical expense tax deduction or credit is permitted for which reimbursement is made.

_____ _____

Employee Signature Date

When done, attach all necessary receipts and **mail, e-mail or efax** to:

Northeast Benefits Management, LLC
P.O. Box 2363, South Burlington, VT 05407-2363
Scan and email: info@nbmus.com
eFax: (802) 304-1009 (Burlington exchange)

NBM
Employee Benefits Simplified