Health Reimbursement Arrangement
Claim Form

To expedite your claim:
- Provide *all* appropriate information.
- Review the reimbursement total before printing.

Employer: _____

Employee Name: _____ Social Security Number: _____

Phone: _____ E-mail: _____

Mailing Address: _____

Health Reimbursement Arrangement Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
➨ *Attach appropriate documentation and submit with this claim form.*		**Total Health Reimbursement Arrangement Expense Claim**		**$**

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Health Reimbursement Arrangement (HRA) with respect to such expenses and that the medical expenses have not and will not be reimbursed under any other health plan coverage. 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 is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Your Health Reimbursement Arrangement (HRA) Plan may be limited by the types of healthcare expenses that may be reimbursed to you. Please read the Summary Plan Description for your HRA Plan to review a list of eligible expenses.

_____ _____

Employee's Signature Date

Fax your claim form and documentation to:

618-654-4624, Attn: HRA Reimbursements

- or -

Mail your claim form and documentation to:

Qualified Plan Services, Ltd.
1000 Broadway, Suite 300
Highland, IL 62249