HRA CLAIM FORM

☐ I will pick up my check - **BRING ID**

EMPLOYEE NAME	LAST 4 DIGITS OF EMPLOYEE SOCIAL SECURITY #	EMPLOYER NAME
PLEASE CHECK IF NEW ADDRESS ☐	DAYTIME PHONE #	YOUR EMAIL

HOME ADDRESS	CITY	STATE	ZIP

DO YOU OR YOUR ELIGIBLE DEPENDENTS HAVE INSURANCE COVERAGE FOR ANY OF THE FOLLOWING:

HEALTH? ☐ YES ☐ NO

DENTAL? ☐ YES ☐ NO

VISION? ☐ YES ☐ NO

Total # of pages included with this claim _____

PLEASE SIGN BELOW

To the best of my knowledge and belief, my statements in this claim form are complete and true.
I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants covered by the group health plan.
I certify that these expenses have not been previously reimbursed under this plan, an HSA, or any other benefit plan and will not be claimed as an income tax deduction, nor will I seek reimbursement from any other source.
I authorize my account to be reduced by the amount requested.

Furthermore, the following person has authorization to speak with FlexBank on my behalf regarding the information contained in this claim:

Name_____

Employee Signature (required) **X**_____ **Date**_____

List Expenses Below + Attach Explanation of Benefits (EOB)

Date of Service	Name of Patient	Description of Service Provided	Amount
		TOTAL	

How to submit claims

- ✓ **via Mail: FlexBank Administrators, 1250 W. Dorothy Lane, Suite 107, Dayton OH 45409**
- ✓ **via Fax: 937.299.7992 or 888.677.9373**
- ✓ **via Email: Claims@FlexBank.net**
- ✓ **via Mobile: http://www.flexbank.net/m/**

Revised April 2016