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

HEALTH REIMBURSEMENT ACCOUNT (HRA) CLAIM FORM

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

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. 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.

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

Name____________________________

Employee's Signature ____ Date ___________________________

Instructions for Submission of Claim Requests

1) Complete the information requested above.
2) Sign and date this form.
3) Attach a copy of the Explanation of Benefits (EOB) report from your health insurance company detailing the benefits that have been paid.
4) Mail, fax or scan/email this form along with your EOB.

Total Pages Sent ______________

Total Reimbursement Expected ______________

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/**

Questions? Call us 888.677.8373 or visit our website www.flexbank.net.

Revised Sept. 2013