



A division of Educators Financial Services, Inc.

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## Health Reimbursement Arrangement Claim Form

**Name:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

Health Out-of Pocket Costs								
Service Provided To	Date Incurred	Office Visit	RX	Dental	Vision	OTC Drugs	Other, Please specify	Amount Incurred
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
<i>Attach appropriate receipts.</i>					<b>Total Health Care Expense Claim</b>			

Health Premium Costs				
Insurance	Premium Amount/Monthly	Months Paid	Automatic Monthly Reimbursements (Circle)	Total
Medical			Yes No	
Dental			Yes No	
Long Term Care			Yes No	

- I certify that all expenses for which reimbursement is claimed by submission of this form were incurred by me or my spouse, or dependent(s).
- I certify that the medical expenses incurred by me or my dependents are qualifying expenses as defined by the Internal Revenue Service Code. If these expenses are not qualified expenses I understand that I will be liable for payment of all related taxes on all ineligible amounts paid out by the Plan.
- I certify that the health expenses claimed have not been reimbursed or cannot be reimbursed under any other health plan coverage.
- I take full responsibility for the accuracy and veracity of all the information I have provided.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date