HRA account Reimbursement form

BENEFITHelp Solutions

To help us process your reimbursement request quickly, please print clearly and return this form as instructed. Please complete all sections of the form. If the form is incomplete or additional information is required, your reimbursement may be delayed. Please do not use a fax cover sheet.

☑ Check box if this claim is to offset a previously submitted ineligible expense.

Section 1 Account holder information

* First name	M.I.	* Last name	* Membership identification or SSN
Kyle	A	Passe	12345678999999

* Mailing address	*City	* State	* ZIP
Mailing Address 1234	City	OR	97123

* Contact number	* Email address	
(503) 555-5555	name@email.com	☑ New address

* Employer	*Group identification (if known)
Employer	123456

Section 2 Reimbursement request

	* Name of dependent or self	* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
1	Kaleb Passe	01/01/14	01/02/14
	* Name of provider or merchant	Product description	* Out-of-pocket cost
	Provider or Merchant	Product Description	$ 5.00
2	Kaleb Passe	01/01/14	01/02/14
	Provider or Merchant	Product Description	$ 4.00
3	Kaleb Passe	01/01/14	01/02/14
	Provider or Merchant	Product Description	$ 3.00
4	Kaleb Passe	01/01/14	01/02/14
	Provider or Merchant	Product Description	$ 2.00

If you need more space, please use page 2. Each page will contain its own total. Please review the timelines and substantiation requirements in your Summary Plan Document for eligibility criteria.

* Total on this form: $ 14.00

Section 3 Authorization (please read and sign below)

I acknowledge and certify that:

- The information submitted with this reimbursement request is accurate and complete to the best of my knowledge.
- I am requesting reimbursement for my own personal expenses.
- These services have already been provided or paid for.
- I have not and will not seek reimbursement for this expense from any other plan or party.
- I understand that BenefitHelp Solutions reserves the right to deny a claim if I have not provided substantiation and it is actually available, or if there is reason to believe the expense is not qualified as defined in my Summary Plan Document.

* Employee signature	* Signature date
X	

Ready to submit? Mail, fax or submit this form online to BenefitHelp Solutions.

Mail: BenefitHelp Solutions, P.O. Box 67230, Portland, OR 97268 Fax: 888-249-5058 Online: benefithelpsolutions.com
Questions? Contact BenefitHelp Solutions at 888-398-8057.

Additional reimbursement requests

Account holder information

*First name	M.I.	*Last name	*Membership identification
Kyle	A	Passe	12345678999999
*Employer			*Group identification (if known)
Employer			123456

Reimbursement request

5	* Name of dependent or self Kaleb Passe		* Service start date (MM/DD/YY) 01/01/14	* Service end date (MM/DD/YY) 01/02/14
	* Name of provider or merchant Provider or Merchant	Product description Product Description		* Out-of-pocket cost $ 1.00
6	* Name of dependent or self Kaleb Passe		* Service start date (MM/DD/YY) 01/01/14	* Service end date (MM/DD/YY) 01/02/14
	* Name of provider or merchant Provider or Merchant	Product description Product Description		* Out-of-pocket cost $ 2.00
7	* Name of dependent or self Kaleb Passe		* Service start date (MM/DD/YY) 01/01/14	* Service end date (MM/DD/YY) 01/02/14
	* Name of provider or merchant Provider or Merchant	Product description Product Description		* Out-of-pocket cost $ 3.00
8	* Name of dependent or self Kaleb Passe		* Service start date (MM/DD/YY) 01/01/14	* Service end date (MM/DD/YY) 01/02/14
	* Name of provider or merchant Provider or Merchant	Product description Product Description		* Out-of-pocket cost $ 4.00
9	* Name of dependent or self Kaleb Passe		* Service start date (MM/DD/YY) 01/01/14	* Service end date (MM/DD/YY) 01/02/14
	* Name of provider or merchant Provider or Merchant	Product description Product Description		* Out-of-pocket cost $ 5.00
10	* Name of dependent or self Kaleb Passe		* Service start date (MM/DD/YY) 01/01/14	* Service end date (MM/DD/YY) 01/02/14
	* Name of provider or merchant Provider or Merchant	Product description Product Description		* Out-of-pocket cost $ 6.00
11	* Name of dependent or self Kaleb Passe		* Service start date (MM/DD/YY) 01/01/14	* Service end date (MM/DD/YY) 01/02/14
	* Name of provider or merchant Provider or Merchant	Product description Product Description		* Out-of-pocket cost $ 7.00
12	* Name of dependent or self Kaleb Passe		* Service start date (MM/DD/YY) 01/01/14	* Service end date (MM/DD/YY) 01/02/14
	* Name of provider or merchant Provider or Merchant	Product description Product Description		* Out-of-pocket cost $ 8.00
13	* Name of dependent or self Kaleb Passe		* Service start date (MM/DD/YY) 01/01/14	* Service end date (MM/DD/YY) 01/02/14
	* Name of provider or merchant Provider or Merchant	Product description Product Description		* Out-of-pocket cost $ 9.00
14	* Name of dependent or self Kaleb Passe		* Service start date (MM/DD/YY) 01/01/14	* Service end date (MM/DD/YY) 01/02/14
	* Name of provider or merchant Provider or Merchant	Product description Product Description		* Out-of-pocket cost $ 10.00

If you need more space, please use additional pages. Each page will contain its own total. Please review the timelines and substantiation requirements in your Summary Plan Document for eligibility criteria.

* Total on this form
$ 55.00