HRA Form

Participant's Name: _____ Social Security Number:_____

The undersigned participant in the Plan requests reimbursement in the amounts shown below:

Please submit a copy of your **Explanation of Benefits** from your health insurance carrier along with this form to:

Medical Care Expense

Please attach additional sheets if needed.

Date Incurred	Name of Service Provider	Describe Expense	Person for Whom Expense Incurred		Net Amount	Indicate if payment is to be made to employee or provider
_____	_____	_____	_____	$	_____	_____
_____	_____	_____	_____	$	_____	_____
_____	_____	_____	_____	$	_____	_____

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred (i.e., services were provided) during a period while the undersigned was covered under the Plan with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, 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 the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

_____ Date_____

Employee's signature

