SecureBenefits

Fax to: 800-421-6737 or email to: customercare2@sbsc.info

HRA REIMBURSEMENT REQUEST FORM

Employee Information:

Employer: _____

Employee Name: _____Social Security #: _____

Daytime Phone Number: _____

Reimbursement Information: please attach EOB and/or proof of service and submit for reimbursement

Date(s) Expenses Incurred	Service Provider/Service performed	Person Receiving Product or Service	Claim Amount
Total claims:			$

Certification:

To the best of my knowledge and belief, my statements in this form are complete and true. I certify that the reimbursement requests I am submitting are IRS eligible expenses and that I have not been previously reimbursed for these expenses nor am I seeking reimbursement for these expenses from insurance or any other source. I also understand that Secure Benefits Systems, its agents or employees will not be held liable if I submit non-IRS eligible expenses for reimbursement. I authorize a deduction in my account in the amount of the reimbursement. I have received the services described above on the dates indicated, and the expenses are my out-of-pocket expenses that qualify as a valid expense under the Plan Year.

_____ _____

EMPLOYEE SIGNATURE **DATE**