



# HEALTH REIMBURSEMENT ARRANGEMENT (HRA) REQUEST FORM

FAX CLAIMS TO: (603) 647-4668 (15 PAGE MAXIMUM)  
 CLAIM SUPPORT: (603) 647-4666 or (888) 401-FLEX  
 EMAIL CLAIM SUPPORT: [claimsupport@benstrat.com](mailto:claimsupport@benstrat.com)  
 MAIL TO: PO Box 1300, Manchester, NH 03105-1300  
 ONLINE ACCOUNT: <http://www.benstrat.com>

**Name:** \_\_\_\_\_ **Company:** \_\_\_\_\_  
**Home Mailing Address:** \_\_\_\_\_  **Check if NEW** **Social Security Number:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Plan Year:** \_\_\_\_\_ **-to-** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **Telephone: Home:** ( ) \_\_\_\_\_  
**E-mail:** \_\_\_\_\_ **Daytime Phone:** ( ) \_\_\_\_\_

### INSTRUCTIONS / REMINDERS

- |   |  |
|---|--|
| <ol style="list-style-type: none"> <li>1. Be sure to attach a <b>COPY</b> of the <u>itemized receipt(s)</u>, or if you have insurance, please send the <u>Explanation of Benefits Statement</u>. <b>KEEP</b> original receipts for your tax records.</li> <li>2. <b>Complete</b> claims received by NOON on Thursday will be generally processed on Monday.</li> <li>3. The <b>participant</b> must <b>sign</b> claim form.</li> <li>4. <i>Incomplete forms or unsigned forms</i> will be <b>returned</b> to the participant and <b>not</b> processed</li> <li>5. Reimbursement requests should be for a minimum of <b>\$25</b> (unless using remaining account balance)</li> </ol> | <p>Health Reimbursement Arrangement documentation may include statements, itemized bills, and/or insurance "Explanation of Benefits" forms. All documentation must show:</p> <ol style="list-style-type: none"> <li>1. The date the expense was <b>incurred</b> (not the date paid).</li> <li>2. The provider of services.</li> <li>3. A description of the service and/or expense.</li> <li>4. The amount of the expense for which you are responsible.</li> <li>5. Note: Cancelled checks, credit card receipts, and balance forward statements are <b>NOT</b> acceptable documentation</li> </ol> |
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### PARTICIPANT STATEMENT & SIGNATURE (Required)

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for IRS eligible expenses incurred by my legal dependents or myself (Domestic/Civil Union Partners are not IRS eligible dependents in most cases). I certify that these expenses have not been and will not be reimbursed from any other source and will not be claimed as an income tax deduction.

**PARTICIPANT SIGNATURE** (REQUIRED) \_\_\_\_\_ **DATE:** \_\_\_\_\_

### HEALTH REIMBURSEMENT ARRANGEMENT EXPENSES REQUESTING REIMBURSEMENT Use second sheet if needed.

Amount to be Reimbursed	Service Date(s)	Description <i>(Not all plans allow all descriptions listed below please refer to your summary plan description for details on your plan)</i>	Person receiving product / service
\$		<input type="checkbox"/> Deductible <input type="checkbox"/> Inpatient Services <input type="checkbox"/> Medical <input type="checkbox"/> Coinsurance <input type="checkbox"/> Outpatient Services <input type="checkbox"/> Prescription <input type="checkbox"/> Other (please describe): _____	
\$		<input type="checkbox"/> Deductible <input type="checkbox"/> Inpatient Services <input type="checkbox"/> Medical <input type="checkbox"/> Coinsurance <input type="checkbox"/> Outpatient Services <input type="checkbox"/> Prescription <input type="checkbox"/> Other (please describe): _____	
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\$		<input type="checkbox"/> Deductible <input type="checkbox"/> Inpatient Services <input type="checkbox"/> Medical <input type="checkbox"/> Coinsurance <input type="checkbox"/> Outpatient Services <input type="checkbox"/> Prescription <input type="checkbox"/> Other (please describe): _____	

**\$** \_\_\_\_\_ **TOTAL Health Reimbursement Requested** include second page total (Payments are made directly to the employee.)

List .....EXPENSES REQUESTING REIMBURSEMENT

**Note: Cancelled checks, credit card receipts, and balance forward statements are NOT acceptable documentation.**

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\$ \_\_\_\_\_ **Total Second Page Requested** Please add the amount to the total on the front page (Payments are made directly to the employee.)