Health Reimbursement Arrangement (HRA)
Reimbursement Request Form

Employer _____

Employee Name _____ Soc.Sec.No. _____
Last First M.I.

Home Address _____
Number/Street City State Zip

Daytime Telephone Number _____ E-mail Address _____

☐ Please check only if this is a new address.

Direct Deposit Authorization – Please complete this section to have your HRA reimbursements direct deposited into your checking or savings account. This is a faster, more secure method of reimbursement. If you are already set up for direct deposit, there is no need to complete again. You may attach a voided check if you are unsure of your routing and/or account number.	
Name of Banking Institution:	Routing Number:
Account Type: ☐ Checking ☐ Savings	Account Number:

Please list the expenses that you are requesting below. For deductible and/or co-insurance charges, you MUST submit a copy of the Explanation of Benefits (EOB) from your insurance carrier. Proof of payment is not required. For more information on eligible Medical Expenses, please refer to your Summary Plan Description.

Date of Service	Patient's Name & Relationship	Description of Service	Provider of Service	Amount of Reimbursement

Total Expenses $_____

I certify that I have not previously requested reimbursement for the above expense under this plan or any other plan, and I will not seek reimbursement from any other health plan coverage or any other source. I also certify that the expenses were incurred by me and/or my IRS dependents, and will not be applied toward any federal or state income tax deduction or credit.

_____

Employee Signature *Date*

You must sign this form to be reimbursed. Mail or fax to:

Arcadia Benefits Group, Inc. • 445 W. Michigan Ave., Suite 102 • Kalamazoo, MI 49007
Phone: 269-744-3431 Toll Free: 866-329-4333 Fax: 269-381-5844 www.arcadiabenefits.com

 Rev. 11/07