

HRA Reimbursement Claim Form

Note: Every item must be completed before the claim can be processed! (Please print in ink or type)

Employer/Plan Name: _____

Enrollee Name: _____

Address: _____

Instructions

1. For medical/dental expense claims that were submitted to a medical plan or an insurance company but not paid by that carrier, attach copies of other insurance carrier claim and/or payment forms (explanation of benefits forms) to establish amounts not covered under the plan.
2. For all other reimbursable expenses, copies of all bills must be attached which show who (name and address) rendered the service, reason for charge and date and amount of charge. Canceled checks are not acceptable receipts. Beginning 1/1/2011, by law, items which may be purchased without a prescription are not reimbursable unless prescribed by doctor (please attach a copy of the prescription).
3. For reimbursements for insurance premiums paid, you must again complete a claim form and submit a copy of the receipt paid, or equivalent, showing the insurance company name and amount that you paid.
4. Submit to the Human Resources Director, City of Columbia City, 112 S. Chauncey St., Columbia City, IN 46725.

Expenses

Expense Item	Date Expense Paid	Reason for Payment*	Amount Paid
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- *Use the following letter designation for "Reason for Payment":
- a. medical/dental expense submitted to insurance company but not paid by the carrier;
 - b. medical/dental expense not covered by a benefit plan;
 - c. vision expenses
 - d. insurance premium expenses
 - e. other

Employee Certification

I certify that all items requested to be reimbursed comply with the Retiree Health Reimbursement Account Plan and such items have not and will not be covered by any other plan or program of any employer or other person. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns for any year. I understand this plan does not accept responsibility for direct payment to any individuals other than the Retiree.

Retiree Signature

Date