HRA Reimbursement Claim Form

If Faxing # of Pages:

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EMPLOYEE INFORMATION *(Please Print)*

☐ Check here if address has changed

Name: _____ SSN: _____

Address: _____ Email : _____

City, State, Zip: _____ Day Phone: _____

UNREIMBURSED HRA EXPENSES *(Attach supporting documentation)*

Does your receipt include all of the following?

☐ Provider's name and address ☐ Patient's name
☐ Service description ☐ Amount billed
☐ Date of service

***** Credit card receipts are not acceptable *****

Person for Whom Expense was Incurred	Date(s) of Service	Name of Service Provider	Description of Services	Amount
		Total Unreimbursed HRA Expenses		$0.00

READ CAREFULLY

The above is a true and accurate statement of all expenses incurred by my eligible dependents or me on the date(s) indicated, and I will not seek reimbursement from any other plan including a Health Savings Account (HSA). I understand that I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax and any associated penalties on the amounts paid for any expense improperly claimed under the provisions of this plan.

_____ _____

Participant Signature Date

Mail To: myCafeteriaPlan, 432 East Pearl St., Miamisburg, OH 45342
Fax To: 937.865.6502 **Email To**: claims@myCafeteriaPlan.com

Access your account information 24 hours a day, seven days a week on our web site: www.myCafeteriaPlan.com