

Health Reimbursement Account (HRA/Section 105) – Expense Claim Form



How to file a claim:

1. Complete all sections of the claim form
2. Make sure the claim form does not include items for more than one Plan Year. Please use separate forms for items incurred in different Plan Years.
3. Support documentation is required. Examples of supporting documentation are explanations of benefits, itemized statements from providers, pharmacy receipts, etc. Do not submit cancelled checks or credit card receipts alone — these are not adequate.

EMPLOYEE INFORMATION

Last Name:	First Name:	Mid:
Street Address:		Apt/Unit#:
Birth Date:	Marital Status:	SS#:
City:	State:	Zip:
Home Phone:	Alt. Phone:	Email:
Employer Name:		
Employer Group Number:		

HEALTH CARE EXPENSES (ITEMIZE EACH EXPENSE TYPE USING A SEPARATE LINE. USE ADDITIONAL FORMS AS NECESSARY)

Patient Name	Type of Service <i>Please check one box for each expense type:</i> MD=MEDICAL; RX=PRESCRIPTION; OTC=OVER-THE-COUNTER; VS=VISION; DN=DENTAL; HR=HEARING	Date of Service (mm/dd/yyyy)	Request Amount
	<input type="checkbox"/> MD <input type="checkbox"/> RX <input type="checkbox"/> OTC <input type="checkbox"/> VS <input type="checkbox"/> DN <input type="checkbox"/> HR	FROM TO	\$
	MD RX OTC VS DN HR	FROM TO	\$
	MD RX OTC VS DN HR	FROM TO	\$
	MD RX OTC VS DN HR	FROM TO	\$
	MD RX OTC VS DN HR	FROM TO	\$
	MD RX OTC VS DN HR	FROM TO	\$
	MD RX OTC VS DN HR	FROM TO	\$
Total Expenses			\$

All sections of this form must be completed and accompanied by a copy of an itemized bill on provider letterhead to be eligible for plan reimbursement.

I certify that any expenses for which I am requesting reimbursement from my HRA, as itemized above, were incurred by me (and/or my spouse and/or eligible dependents) for medical care as permitted by the HRA, and have not been reimbursed and I will not seek reimbursement under any other plan. I understand that expenses reimbursed through the HRA program cannot be used to claim any federal income tax deduction or credit. To the best of my knowledge and belief, my statements are complete and true.

EMPLOYEE'S SIGNATURE	DATE
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PLEASE RETURN COMPLETED FORM TO:

Great Bay Administrators, 37 Industrial Drive Exeter, NH 03833,
or submit through our secure portal