Prodegi
Corporate Benefit Services

HEALTH REIMBURSEMENT ACCOUNT CLAIM FORM

THIS FORM IS TO BE COMPLETED BY EMPLOYEE					
PARTICIPANT NAME	GROUP NUMBER		PARTICIPANT'S ID NUMBER	NAME OF EMPLOYER	
PARTICIPANT'S STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER	DATE SUBMITTED

What to submit to my HRA?

(Submit explanation of benefits (EOB) from Health, Dental and/or Vision Insurance Plan. If no insurance coverage, submit itemized bills, receipts and/or invoices for all expenses.)

CLAIMANT	DATE OF SERVICE	SERVICE PROVIDED	AMOUNT REIMBURSABLE
		Total Amount Reimbursable	

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred (i.e., services were provided) during a period while the undersigned was covered under the Plan with respect to such expenses and that such expenses have not been reimbursed, or are not reimbursable, under any other health plan coverage / Section 125 Flexible Benefit Plan. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense. The undersigned further understands that no medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

_____ _____

Participant's signature Date

Prodegi

PO Box 98
Worland, Wyoming 82401
Phone: 307-426-5500/800-246-4622
Fax: 307-347-6227