Health Reimbursement Arrangement (HRA) Claim Form

CBIZ Flex

Version 3.01.09

Employer:		**Participant:**			
Email:		**SSN:**	- -	**Phone:**	( ) -

Healthcare Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount

~Attach appropriate receipt(s) and submit with this claim form.	**Total Healthcare Expense Claim**	

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 during a period while the undersigned was covered under the company's HRA Plan with respect to such expenses, and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage and that they were incurred by the participant or a legal dependent of the participant. The undersigned fully understands that he or she 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 payment of all related taxes including federal, state, and or local income tax on amounts paid from the Plan which relate to such expense. Please read the Summary Plan Description for your HRA plan for additional information.

(Please keep a copy for your records)

Participant Signature **Date**

Claim Forms can be mailed or faxed to: CBIZ Payroll, Attn: Flex 2797 Frontage Road, Suite 2000 Roanoke, VA 24017 Fax: **800-584-4185**
Phone: 800-815-3023 option 4 Email: cbizflex@cbiz.com **Visit www.myplans.cbiz.com to submit claims, verify receipt, or check account balance.**