Health Reimbursement Arrangement (HRA) Claim Form

Employee Name:		Social Security #:	
Street Address:			
City:		State:	Zip:
Home Phone:	Business Phone:		
Email Address:			

For all reimbursable expenses, a copy of the most recent explanation of benefits (EOB) must be attached to the claim form. Electronic Checks, Canceled Checks, and Credit Card Receipts are NOT acceptable receipts.

Date of Expense Paid	Description of Expense	Amount

Employee Certification

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

______________________________________ ________________________

Employee Signature **Date**

FAX TO:	MAIL TO:	QUESTIONS:
1-210-738-1341 PAGE ________ OF ________ NO COVER PAGE REQUIRED	EBS Third Party Administration 45 NE Loop 410, Suite 690 San Antonio, TX 78216	800-299-3539 MWilson@SpireRM.com