BeneFlex
77 Brant Avenue, Suite 206, Clark, NJ 07066 Phone (732) 428-8282
Email submission to: claims@flexaccount.com or Fax: (732) 428-8111

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) ACCOUNT CLAIM FORM

Indicate Payee: ❑ **Pay Participant** ❑ **Pay Service Provider (pay only one per form)**

Part I: Participant Information

Company Name:
Participant Social Security Number:
Participant Name (Last/First/MI):
Participant E-mail:
Participant Daytime Phone Number:

Part II: Provider Information

Provider Name:	
Provider Address:	
Provider City, State and Zip Code:	
Provider Telephone	**Provider Taxpayer Identification Number (EIN):**

****Explanation of Benefits (EOB) Must Accompany This Request !!!!**
****All Provider Fields Listed Above Must Be Completed**

Part III: Medical Reimbursement Request

	Dates of Service Beginning Date to Ending Date		Primary or Dependent and Relationship	Expense Description	Reimbursement Requested
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
	Total Reimbursement Requested >>>				$

TO EXPEDITE CLAIM PAYMENT, PLEASE COMPLETE AND SIGN YOUR CLAIM FORM

Part IV: Employee Certification for Reimbursement

I hereby certify that:
* All expenses for which reimbursement/payment is requested under the Plan were incurred by myself or, my eligible dependents within the Plan Year of the service date.
* If the "Pay Participant" box above is checked then, expenses have been paid by me and that in the case of qualifying medical expenses, they have not been reimbursed or are not reimbursable under any other medical coverage; and
* I will not use qualifying medical expenses reimbursed through this medical reimbursement account as deductions when filing my Federal Income Tax return.

I understand that:
* I am fully responsible for the sufficiency and accuracy of all information relating to medical claims which are provided by me; and
* I may be liable for payment of all related taxes and penalties including interest and penalties for the late payment by the Employer for the Employer's share of Social Security and unemployment taxes on amounts paid from the Plan which relate to such expense if the expense is not a qualifying expense under the Plan.
I am responsible for and liable to the Employer and/or BeneFlex, Inc. for any reimbursement I may receive in excess of my contributions/entitlements to such Plan.

I further certify that:
* If I have checked the "Pay Service Provider" box above I am authorizing BeneFlex, Inc. to make payment directly to the Provider named on my behalf and in lieu of reimbursement to me.

I hereby authorize release of payment based on the rules stated above herein and in accordance with Plan guidelines.

Employee Signature: ______________________________ **Date:** __________________