HRA Code 105 * Reimbursement Request Form

Employer Name _____ Social Security Number _____ (____) _____ Work Phone

Last Name _____ First Name _____ M. I. _____ (____) _____ Home Phone

Change of Address: _____ City: _____ State: _____ Zip: _____

Plan Participant **Check Box to file difference on your FSA Account :** ☐

In order to request reimbursement through your HRA benefit you must complete this form, attach a copy of your Explanation of Benefits (EOB) provided by your health plan, and sign below.

Date of Expense	Name/Relationship (You must indicate Self, Spouse or Child)	Type of Expense (Co-Pay, Rx, Vision)	Total Expense
		Voucher Total:	

I certify that the expenses listed above have been incurred by me and/or my eligible dependents and qualify for reimbursement. I have not been reimbursed for these expenses nor are the expenses reimbursable under any other health and/or dependent care assistance plan. I am not applying these expenses toward any federal or state income tax deduction or credit. I will assume all responsibility for any taxes or penalties arising out of any disallowed deductions.

Your Signature _____ Date _____

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

WORKSITE BENEFIT PLANS, INC.

Phone 405/616-0122 **8524 South Western, Suite 106 Oklahoma City, OK 73139** **Fax 405/616-0121**

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