A Division of HUB International
www.hubinternational.com
1250 Tower Lane
Erie, PA 16505
(814) 454-0167

HRA REIMBURSEMENT FORM

- Please complete this form and attach the **Explanation of Benefits (EOB)** from the insurance company.
- If the Explanation of Benefits is not included, your request for deductible reimbursement will be **denied**.
- The employee is responsible for payment to the provider.
- Email this form to: Benefit Administrators at BAI.CDH@hubinternational.com
  Questions: (814) 454-0167 or (800) 777-2524

Employee First Name:	MI:	Employee Last Name:	Last 4 digits of SSN
Employee Address:			
Employee Email Address:			
Employer Name:			

DESCRIPTION OF EXPENSES AND REIMBURSEMENT AMOUNTS:

Patient's Name	Relationship	Date of Service	Service Provider	HRA Expense

*** TOTAL CLAIM AMOUNT:**

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

To the best of my knowledge and belief, my statements on this form are complete and true. I certify that my family member or I have received the services described above on the dates indicated and that the expenses qualify as valid medical expenses under the plan. I certify that these expenses have not been reimbursed under any other plan, nor will I seek reimbursement for any of these expenses elsewhere. I understand that these expenses may not be used to claim any Federal income tax deduction or credit. **Any person who, with intent to defraud or knowing they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud or healthcare fraud under state and/or federal law.**

Employee's Signature _____ **Date** _____