NOTICE: THIS CLAIM FORM SHOULD BE USED BY HRA PARTICIPANTS WHO BY PLAN DESIGN ARE REQUIRED TO EXHAUST **SECTION 125 MEDICAL FSA FUNDS FIRST BEFORE** YOU ARE ELIGIBLE TO SUBMIT EXPENSES TO THE HRA.

SECTION 125 FSA (1ST)/HRA CLAIM FORM

INSTRUCTIONS: FAILURE TO COMPLETE ALL SECTIONS OF THE FORM WILL DELAY PROCESSING OF YOUR CLAIM. Complete all personal information. Indicate the incurred date(s) of the expense, Provider name/Dependent information, and the dollar amount eligible for processing. Attach copies of the documentation (Explanation of Benefits (EOB), etc.) that will include the incurred date/service date (not paid date), and a description of the service provided. Please sign the claim form below, attach copies of appropriate documentation, and forward by fax OR mail (not both) for processing.

Employer Name_____

Employee Name _____ Daytime Phone (____)_____
Last First Middle Initial

Employee ID (assigned by Benefits Design) or Social Security Number (last 4 digits) _____

Employee Address _____ ☐ **Check if new address**
Street City State Zip Code

ADULT CHILD CLAIM* (Check if applicable)		**SERVICE DATES START DATE-END DATE**	**AMOUNT**	**PROVIDER NAME/ DEPENDENT NAME** (i.e. XYZ Hospital/John)	**For Office Use Only** FSA $ to be paid	HRA $ to be paid	Office Use
❑	1.	_____ - _____	_____	_____	_____	_____	_____
❑	2.	_____ - _____	_____	_____	_____	_____	_____
❑	3.	_____ - _____	_____	_____	_____	_____	_____
❑	4.	_____ - _____	_____	_____	_____	_____	_____

TOTAL _____

***ADULT CHILD CLAIMS ONLY:** **HRA Reimbursements are only issued to the participant, however, if additional information is required to process the claim for an adult child and you wish to have this request directed to an address other than the participant address above, please provide that address in the space below:**

_____
Name of Adult Child Street City State Zip Code

I certify that the above information is correct and that the expenses claimed were incurred by me, my spouse, or by my eligible dependents after my effective date of coverage in my employer's benefit plan. The submitted expenses are valid Qualified Medical Expenses as defined in the Plan Document**.** I further certify that once I have exhausted the funds in my Section 125 FSA (if any) as required by the ordering rules, any unpaid expenses may be automatically filed in the HRA if applicable. I further certify that none of the expenses above that will be filed with the Section 125 flexible spending plan if I have elected to participate and/or automatically filed with the HRA plan have not been or will not be reimbursed by any other source and that I have not and will not claim these expenses on my personal income tax return. I acknowledge that if my coverage under the Health Reimbursement Arrangement (HRA) and/or the Flexible Spending Account (FSA) does not constitute permitted non-HDHP coverage I am not eligible for Health Savings Account (HSA) contributions while covered under the HRA and/or FSA plan.

EMPLOYEE SIGNATURE _____ DATE _____

BENEFITS DESIGN GROUP, INC. PO BOX 370 Onalaska, WI 54650 1-800-342-8235 or (608) 781-2159 FAX (608) 781-4576 www.bdgflex.com