cbia health connections

HRA REIMBURSEMENT FORM

An Explanation of Benefits (EOB) must be attached for each person/date of service.

Employer Name _____ Group Number _____
please print

EMPLOYEE INFORMATION

Name _____ Social Security Number _____
please print

Street Address _____

City _____ State _____ Zip _____

Work Telephone _____ Home Telephone _____

ELIGIBLE MEDICAL EXPENSES

Name of Person Receiving Service	Description of Services Provided	Name of Provider / Facility	Date of Service	Requested Reimbursement Amount
			Total ▶	

I understand, agree and certify to the following:

I will use my HRA to pay for IRS-qualified expenses permitted under my employer's HRA plan that is provided to me and my IRS-eligible dependents enrolled in this plan. I have not and will not seek reimbursement for the medical expenses claimed on this HRA form through any other source. Prohibited sources include, but are not limited to, individual and group health insurance, HMOs, self-insured plans, etc. I will not claim any reimbursed HRA expense for federal income tax deduction or credit, and will request reimbursement only after the services have been provided. I will collect and maintain sufficient documentation to substantiate my reimbursed HRA expenses to respond to any IRS or employer inquiries that I may receive. Claims under the plan shall be submitted by 90 days after the end of the plan year or, if earlier, within ninety (90) days after I cease to participate in the plan. Any claims for a plan year submitted after 90 days after the end of the plan year or, if earlier, within ninety (90) days after I cease to participate in the plan, shall not be reimbursed. The eligibility of medical expenses under an HRA plan is subject to IRS and FDA regulatory change at any time. I specifically release my employer and CBIA Service Corp. from any liability resulting from either my participation in any HRA or any misrepresentation I make regarding my HRA requests for reimbursement. Where reimbursement of ineligible HRA expenses has been made, the corrective procedures approved by the IRS and permitted under my employer's HRA plan will be followed. I have read and understand the information described above.

Participant's Signature: _____ Date:_____

Mail Form and Supporting Documentation to:
CBIA HRA Services
350 Church Street
Hartford, CT 06103-1126

Or fax to: (860)278-0883

Office Use Only	Date	Authorized By