HRA Reimbursement Claim Form

Employer _____ ☐ **Here if change of address** _____

Name _____ **MEMBER ID #** _____

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Incurred
		TOTAL MEDICAL CARE EXPENSE CLAIM		

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Employer's HRA Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Employee's Signature _____ Date _____

Please mail completed form and required documentation to:
Fax: 518-244-4262
Email: rkflex@rkinsurance.com

Rose and Kiernan Inc.
RKFlex Deparment
99 Troy Road
East Greenbush, NY 12061