Health Reimbursement Arrangement
Claim Form

THIS SIGNED FORM MUST ACCOMPANY EACH GROUP OF RECEIPTS SUBMITTED

Employer				
Employee Last Name: (Please Print)	Employee First Name	Employee Middle Initial	SSN	
Home Address	City	State	Zip Code	
Email Address	Daytime Phone Number ( ) -			

☐ Please check if new address or email address

To the best of my knowledge and belief, my statement in this Request for Reimbursement is complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. If this claim includes medical expenses, I certify that these expenses have not been reimbursed, are not reimbursable from any other source, nor will any reimbursement be sought from any other source. I authorize my Health Reimbursement Arrangement Account to be reduced by the amount requested.

Employee Signature: _____ Date: _____

Signature Required

Expenses must be incurred within the appropriate Plan Year and prior to reimbursement. Expenses that may be covered by your (or your spouse's) primary plan must first be submitted to the appropriate insurance carrier. The Explanation of Benefits (EOB) you receive from your insurance carrier must be submitted to *FlexPro* as a qualifying receipt towards your *FlexPro* HRA Plan.

Name of Patient or Dependent	Date(s) of Service	Name of Provider or Merchant	Type of Service or Supply	Health Care Charge for each service/supply	Flex Card Purchase Substantiation

If necessary please add additional page: **TOTAL**

Attention Benefits Payment System (BPS) Benefits Card® Flex Card Users:

- ☐ None of the attached claims were purchased using my Flex Card
- ☐ Some of the claims were purchased using my Flex Card. Please check claim(s) purchased with your Flex Card.
- ☐ All of the attached claims were purchased using my Flex Card.

The following reimbursement request rules apply: Health Care expenses must be incurred within the appropriate Plan Year. See Plan Specific page for eligibility requirements. Photocopies of receipts are acceptable. Please retain a copy of all receipts for your own records. *Cancelled checks are not acceptable receipts*. This form must be signed and submitted with applicable receipts.

Claims may be submitted to:

Mail: Key Benefit Administrators - P.O. Box 1179 – Ft. Mill, SC 29716-1179

Fax: 866-241-1488

Email: Flexpro@keybenefit.com

Online: www.benefitspaymentsystem.com