# HEALTH REIMBURSEMENT ACCOUNT (HRA) CLAIM FORM

**NAME:** _____

**ID NUMBER:** ____ – ____ – ____

**ADDRESS:** _____

_____

**PHONE NUMBER:** _____

**SEND CLAIMS TO:**
Group Administrators, Ltd.
Attention: HRA Administration
953 American Lane, Suite 100
Schaumburg, Illinois 60173

E-Mail: chra@groupadministrators.com
Telephone: (800) 487-1150
Fax: (847) 519-1979

____ **Check if Name Change** ____ **Check if Address Change**

**EXPENSES TO BE REIMBURSED: (Please Itemize)**

| Date Medical Service Actually Provided | Provider Name or Facility of Service | Patient Name/ Relationship | Total Expense | Amount Paid by Insurance or Other Plan | Reimbursement Requested |
|---|---|---|---|---|---|
| **1.** | | | **$** | **$** | **$** |
| **2.** | | | **$** | **$** | **$** |
| **3.** | | | **$** | **$** | **$** |
| **4.** | | | **$** | **$** | **$** |
| **5.** | | | **$** | **$** | **$** |
| **6.** | | | **$** | **$** | **$** |
| | | | | **Total Requested** | **$** |

Please include appropriate documentation required with this completed claim form as follows:
If covered by insurance, provide the insurance payer's Explanation of Benefits Statement. If not covered by insurance, provide an itemized statement from the provider of care. An itemized statement must include the provider name/address, patient name, description of the type of service provided, date the service was provided (not when you paid or were billed), and the dollar amount. Prescriptions require the pharmacy receipt, pharmacy printout, or the mail-order itemized statement.

**Note:** Examples of unacceptable documentation include cancelled checks, credit card receipts, balance forward/amount due/paid-on- account statements, pre-treatment estimates or statements for future dates of service.

**I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by me, an eligible spouse, or an eligible dependent during a period while I was covered under the HRA Plan and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. I understand that I am fully responsible for the accuracy of all information relating to this claim, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. A claim will only be processed with a completed and signed claim form and correct documentation.**

**SIGNATURE:** _____ **DATE:** ____/____/____

# Group Administrators, Ltd.

953 American Lane, Suite 100 • Schaumburg, IL 60173 • (847) 519-1880 • Fax (847) 519-1979


## Direct Deposit Agreement Form

### Authorization Agreement

I hereby authorize Group Administrators to initiate automatic deposits to my account at the financial institution named below. I also authorize Group Administrators to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold Group Administrators responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until Group Administrators receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

### Employee Information

Employee Name: _____

Social Security Number or Alternate ID: _____

### Account Information

Name of Financial Institution: _____ ☐ Checking | ☐ Savings

Routing Number: ☐☐☐☐☐☐☐☐☐

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

### Signature

Authorized Signature: _____ Date: _____

**Please attach a voided check.**