



CHICAGO TRANSIT AUTHORITY—RETIREE HEALTH CARE TRUST

c/o Group Administrators, Ltd. • 20 North Martingale Rd., Suite 290, Schaumburg, IL, 60173

HEALTH REIMBURSEMENT ACCOUNT (HRA) CLAIM FORM

NAME: _____

ID NUMBER: _____ - _____

ADDRESS: _____

PHONE NUMBER: _____

____ Check if Name Change ____ Check if Address Change

SEND CLAIMS TO:

Group Administrators, Ltd.
Attention: HRA Administration
20 North Martingale Rd., Suite 290
Schaumburg, Illinois 60173

E-Mail: chra@groupadministrators.com
Telephone: (800) 487-1150
Fax: (855)-978-2331

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: ____ / ____ / ____