Company Name:_____

REQUEST FOR REIMBURSEMENT

I. Participant Identification

(Please print or type)

Participant Name: _____

Social Security Number:_____-_____- _____

II. Invoices attached

(Please attach a separate sheet if more space is needed)

Date of Service	Physician or other Provider	Amount
_____	_____	$_____.___
_____	_____	$_____.___
_____	_____	$_____.___
_____	_____	$_____.___

III. Total Amount Requested $_____.___

IV. Statement by Participant

The medical expenses hereby presented for reimbursement from the Plan have not been reimbursed and will not be reimbursed through any other health plan coverage, including other medical flexible spending arrangements.

_____ _____

Participant's Signature Date

For Administrative use only

Reviewed by: _____ Date: _____

Plan code: _____ Employee number: _____

Plan Year: ___ Benefit code: _____

Approval

Trans. type: ____ As of: / /___ Approved: $_____.___

Denial

Trans. type: ____ As of: / /___ Denied: $_____.___

Reason for Denial: _____

Action to be taken:_____

P.O. Box 7
Fort Edward NY 12828
Phone: 518-338-3500
Fax: 518-338-3502

HEALTH REIMBURSEMENT ARRANGEMENT
REIMBURSEMENT REQUEST FORM

Explanation to Participants

To submit a request for reimbursement, you must complete this form, sign it and attach the documentation needed to verify that your expenses are qualified for reimbursement under the Plan. Return the completed form with the documentation attached to your Benefits Coordinator.

**** Invoices Attached ****
Please list the invoices or statements which are attached. These documents must be invoices or other written statements from the third parties who provided the medical services and must show the names of the providers, the dates that services were provided, the amounts charged for the services, and a brief description of the services. Please refer to the Summary Plan Description and the Plan document for a more complete explanation of qualified expenses.

Expenses must be for services that you received during the same period that you are an HRA Participant. For example, if your enrollment begins on February 1, you can submit a claim for a February 1 doctor's visit, but not for a doctor's visit on January 31, even though you don't receive a bill until February 15.

**** Total Amount Requested ****
Please enter the total amount that you are requesting for reimbursement, based on the documentation you have attached.

**** Statement by Participant and Signature ****
Besides providing the information that is needed to prove that your claim is for qualified for reimbursement, you must sign the form, thereby swearing that you have not and will not submit these expenses for reimbursement from another Plan. For example, if you are covered by more than one medical insurance policy or more than one medical flexible spending arrangement, you cannot receive a reimbursement from this Plan and from the other Plan, too.