HRA REIMBURSEMENT REQUEST FORM

Instructions:

You may reimburse medical expenses that apply to the *second half* of your deductible. This form MUST be completed to receive reimbursement for out-of-pocket medical expenses for your Health Reimbursement Account. These services MUST have been incurred during the current Plan Year. An itemized copy of the provider's itemized bill or your insurance company's Explanation of Benefits (EOB), verifying the date and cost of the service MUST be attached to this form. Your claim WILL NOT be processed until these items are received by Human Resources. Credit card receipts and cancelled checks WILL NOT be accepted.

Return completed form & documentation to:

Mail:	**Fax:**	**Email:**
TMF Center, Inc.	(765) 762-0100	chrisf@tmfcenter.com
ATTN: Chris Fruits	ATTN: Chris Fruits	ATTN: Chris Fruits
300 W. Washington St		
Williamsport, IN 47993		

Plan Year

Employee Last Name	**First**	**MI**	**Date of Birth**	**SSN**

Employee Street Address	**City**	**State**	**Zip**

Employee Day Phone	**Employee Email**
( ) -	

UNREIMBURSED MEDICAL EXPENSES (QUILIFYING MEDICAL EXPENSES FOR YOU AND ANY TAX DEPENDENTS)

See Internal Revenue Code 213 for qualifying health care expenses or consult your tax advisor for more information.

Date Expense Incurred (mm/dd/yyyy)	Provider (e.g. clinic, pharmacy, doctor, ect.)	Description of Expense	Relation to Participant	Amount Paid (total expense)	Amount Paid by Insurance (if any)	Amount Paid by You
			Self ________ Spouse _______ Dependent ____	$	$	$
			Self ________ Spouse _______ Dependent ____	$	$	$
			Self ________ Spouse _______ Dependent ____	$	$	$
			Self ________ Spouse _______ Dependent ____	$	$	$
			Self ________ Spouse _______ Dependent ____	$	$	$

Total Unreimbursed Claims	$

To the best of my knowledge and belief, my statements on this Request for Reimbursement are complete and true. I understand that I am solely responsible for the validity of claims submitted to my Health Reimbursement Account. I am claiming reimbursement only for eligible expenses incurred by myself, spouse and/or covered dependents. I certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance. I hereby authorize my Health Reimbursement Account to be reduced by the amount shown above.

Employee Signature	Date