

PLAN YEAR \_\_\_\_\_

## HRA REIMBURSEMENT FORM

PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM PRIOR TO COMPLETION.  
PLEASE STAPLE SUPPORTING DOCUMENTATION TO THE BACK OF THIS FORM.

NAME \_\_\_\_\_ HOME PHONE (\_\_\_\_) \_\_\_\_\_ DAY PHONE (\_\_\_\_) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ EMPLOYER \_\_\_\_\_

SUMMARY OF IRS-ELIGIBLE MEDICAL EXPENSES				DATES SERVICE PROVIDED, NOT PAID		
Name of Person Receiving Service	Relationship to Employee	Provider of Services	Co-pay / Co-insurance /Deductible Amount	From (Mo /Day /Yr)	To (Mo /Day/Yr)	Amount to Be Reimbursed
<b>TOTAL</b>						

I UNDERSTAND, AGREE AND CERTIFY TO THE FOLLOWING:

- I will use my HRA to pay for IRS-qualified expenses, permitted under my Employer's HRA plan(s) provided to me and my IRS-eligible dependents, on the date(s) indicated above as being incurred within my period of coverage.
- I have not and will not seek reimbursement for the medical expenses claimed on this HRA form through any other source. Prohibited sources include, but are not limited to, individual and group health insurance, HMOs, self-insured plans, etc.
- I will not claim any reimbursed HRA expense for federal income tax deduction or credit, and will request reimbursement only after the services have been provided.
- I will collect and maintain sufficient documentation to substantiate my reimbursed HRA expenses to respond to any IRS or Employer inquiries I may receive.
- The eligibility of medical expenses under an HRA Plan is subject to IRS and FDA regulatory change at any time.
- I specifically release my Employer and FBMC from any liability resulting from either my participation in any HRA or for any misrepresentation I make regarding my HRA requests for reimbursement.
- Where improper reimbursement of ineligible HRA expenses has been made, the corrective procedures approved by the IRS and permitted under my Employer's HRA Plan will be followed.
- I have read and understand the information on the front and back of this form.

PARTICIPANT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

OFFICE USE ONLY	DATE	AUTHORIZATION	INITIALS
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# INSTRUCTIONS FOR HRA REIMBURSEMENT

To assure the quickest turnaround and best service, please read these instructions carefully.

## General HRA Reimbursement Request Instructions

- Contact FBMC Customer Service by e-mail at: [webcustomerservice@fbmc-benefits.com](mailto:webcustomerservice@fbmc-benefits.com), or call 1-800-342-8017 to request information or assistance.
- HRA Reimbursement Request Forms will be returned unprocessed if the instructions on this form are not followed.
- Refer to your Employer's current plan year Reference Guide for information on participation rules, expense eligibility, type of supporting documentation required, and other guidelines.
- To request reimbursement of an eligible HRA expense, supporting documentation is required with your reimbursement request and described further in the instructions under each section below.
- You must maintain copies of the information and documentation you submit for all reimbursed HRA expenses to respond to any IRS inquiries you may receive.
- Cancelled checks and charge receipts (or copies) are not acceptable receipts by the IRS to support the reimbursement of HRA expenses.
- You may not request reimbursement until services have been provided, regardless of when you paid for the service.
- If dates of provided services begin in one plan year and end in the next plan year, and you are enrolled in the HRA both plan years, you must submit a separate HRA Reimbursement Request Form for each plan year in which the services were provided.
- Information on any grace period within which you may submit eligible HRA expenses incurred during your period of coverage within a plan year can be found in the "HRA Guidelines" section in your Employer's current plan year Reference Guide.
- Your supporting documentation must be legible.
- You must read over your HRA Reimbursement Request Form to ensure that you have signed, dated and completed it, and attached any required supporting documentation.

## Additional HRA Reimbursement Request Instructions

- Make sure you complete the form in its entirety.
- To request reimbursement of an eligible HRA expense, the following minimum supporting documentation is required: a copy of a receipt, invoice or bill from the provider showing the date service(s) were received, the cost of the service(s), the type of service(s) incurred, and the name of the IRS-eligible person(s) for whom the service(s) were provided.
- Caution: IRS Pub. 502 is intended to help you decide what expenses are deductible on Schedule A to IRS Form 1040. No portion of IRS Pub. 502 should be relied upon to help you decide what expenses are reimbursable under an HRA plan.
- If the medical coverage is not provided through an HMO, you must attach an Explanation of Benefits (EOB) from the health insurance provider showing the date service(s) were received, the cost of the service(s), the type of medically necessary service(s) received, the name of the IRS-eligible person(s) for whom the service(s) were provided, and any uninsured portion of the cost.

### MAIL OR FAX TO:

Fringe Benefits Management Company (FBMC)

Post Office Box 1800

Tallahassee, FL 32302-1800

**FAX: (850) 425-4608**

Do not mail the copy of your faxed transmittal to FBMC.

**PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS.**

FBMC CUSTOMER SERVICE: (800) 342-8017 or [webcustomerservice@fbmc-benefits.com](mailto:webcustomerservice@fbmc-benefits.com)

FBMC WEB SITE ADDRESS: <http://www.fbmc-benefits.com>