Health Reimbursement Arrangement (HRA) Claim Form

To expedite your claim:

- ***Provide all appropriate information including valid receipts.***
- ***Review the Total Expense Claim amount before submitting.***
- ***Sign and date your Claim Form.***

Employer:

Employee Name: ***Social Security Number:***

Phone: ***E-mail:***

Health Reimbursement Arrangement Expense Claims				
Date Expense Incurred	*Name of Service Provider*	*Expense Description*	*Person for Whom Expense Incurred*	*Net Amount*
Attach appropriate receipt(s) and submit with this claim form.		*Total Health Reimbursement Arrangement Expense Claim*		*$*

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Health Reimbursement Arrangement (HRA) with respect to such expenses and that the medical expenses have not and will not be reimbursed under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense. IMPORTANT: *Valid IRS approved receipts for each transaction must be submitted with this Claim Form for all requested reimbursements. Credit card slips and cancelled checks are not considered valid receipts. Under your HRA, the best receipt for reimbursement is your Explanation of Benefits (EOB) from your Health Insurance company.*

Your Health Reimbursement Arrangement (HRA) Plan may be limited by the types of healthcare expenses that may be reimbursed to you. Please read the Summary Plan Description for your HRA Plan for a list of eligible expenses.

Employee Signature **Date**

Mail or Fax Claim Form and Receipts to:

BMS LLC

P.O. Box 43653, Louisville, KY 40253-0653

FAX YOUR CLAIM TO: (502) 244-1162 OR SCAN AND E-MAIL TO: claims@bmsllc.net