RICKENBACH CONSTRUCTION INC

HRA Reimbursement

REIMBURSEMENT CLAIM FORM

EMPLOYEE NAME:

PLAN YEAR:

DATE EXPENSE INCURRED	NAME OF SERVICE PROVIDER	EXPENSE DESCRIPTION	PATIENT NAME	AMOUNT

TOTAL

PLEASE ATTACH A COPY OF THE PAID BILL, INVOICE OR RECEIPT TO SUPPORT THIS CLAIM

I CERTIFY THAT THESE MEDICAL EXPENSES ARE NOT REIMBURSABLE UNDER ANY OTHER HEALTH PLAN COVERAGE .

I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR THE ACCURACY AND VERACITY OF ALL INFORMATION RELATING

TO THIS CLAIM, AND THAT IF IT IS NOT A PROPER HRA EXPENSE I WILL BE LIABLE FOR PAYMENT OF RELATED TAXES.

SIGNED: