



Please attach supporting documentation behind this Claim Form.

Reimbursement Request for



Enter your employer's name

★ = Required Fields

★ Employee Name:

★ Social Security No.:

Address:

Daytime Phone:

Address Change Requested E-Mail Address: _____ Check here if this is a new E-Mail

HRA Claim(s)

(Do Not Complete Shaded Area)

Date of Service	Name of Service Provider	Name & Relationship of Patient	Amount Requested for Reimbursement	Account Breakdown
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				

READ CAREFULLY

I certify that the expenses listed above are not eligible for reimbursement from any other source. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code. I also understand that reimbursement expenses cannot also be claimed as credits or deductions on my personal tax return.

★ Employee's Signature

Date

PLEASE NOTE:

- Most employers have a minimum reimbursement amount of \$40.00.
- Claims with incomplete information or without proper attachments will be returned to you.
- You will have a run-off period after the plan year ends to submit expenses incurred during the plan year. Consult your Human Resources Department. Any monies remaining in your health care account will be forfeited.
- Keep a copy of all expenses claimed for your records. The validity of expenses is your responsibility in the event of an audit by the IRS.

csONE BENEFIT SOLUTIONS
HEALTH REIMBURSEMENT ARRANGEMENT
INSTRUCTIONS AND GUIDELINES

Please complete all sections:

1. Employee Information
2. Health Reimbursement Arrangement Claims
3. Certification Statement

Please Submit:

1. Completed Claim Form with:

- Name of Employee
- Date of Service(s)
- Name of Service Provider(s)
- Name(s) and Relationship of Patient(s) to Participant
- Amount(s) Requested for Reimbursement
- **Employee's Signature**

2. Explanation of Benefits:

A copy of Explanation of Benefits (EOB) is acceptable

Note: Eligible Health Reimbursement Claims are qualified medical/dental expenses of the employee, spouse and dependent(s) that are not eligible for reimbursement from any other source.

Deliver/ Mail/ Fax/ E-mail this completed form with attachments to:

Flexible Benefits Department - csONE Benefit Solutions

Mailing Address: PO Box 1320, Concord, NH 03301-1320

Phone: 1 888 227-9745 ext. 2040 **FAX:** 1 603 224-0230

E-Mail: flexiblebenefits@csONE.com

Located at: Two Delta Drive, Suite 301, Concord, New Hampshire



Benefit Solutions. It's what we do.

www.csONE.com

If you apply for reimbursement of expenses that the IRS later determines to be ineligible, those reimbursements may be taxed as ordinary income and certain penalties may apply, according to the Internal Revenue Code. Similar treatment will be applied to overpayment of reimbursed expenses or reimbursement of expenses that have already been reimbursed from some other source.