Educators Benefit Consultants, LLC
Third Party Administrator

3125 Airport Parkway, Cambridge, MN 55008
Metro: 763-552-6053 Toll Free: 888-507-6053 Fax: 763-552-6055
www.ebcsolutions.com

Health Reimbursement Arrangement (HRA)
Claim Form

NAME: _____ SSN: _____

ADDRESS: _____

PHONE: _____ EMPLOYER: ISD No. 709

Health Out-of Pocket Costs								
Service Provided By	**Date Incurred**	**Office Visit**	**RX**	**Dental**	**Vision**	**OTC Drugs**	**Other, Please specify**	**Amount Incurred**
		○	○	○	○	○		
		○	○	○	○	○		
		○	○	○	○	○		
		○	○	○	○	○		
Attach appropriate receipts.				**Total Health Care Expense Claim**				

Health Premium Costs				
Insurance	**Premium Amount/ Monthly**	**Months Paid**	**Automatic Monthly Reimbursements (Circle)**	**Total**
Medical			Yes No	
Dental			Yes No	
Long Term Care			Yes No	

- I certify that all expenses for which reimbursement is claimed by submission of this form were incurred by me or my spouse, or dependent(s).
- I certify that the medical expenses incurred by me or my dependents are qualifying expenses as defined by the Internal Revenue Service Code. If these expenses are not qualified expenses I understand that I will be liable for payment of all related taxes on all ineligible amounts paid out by the Plan.
- I certify that the health expenses claimed have not been reimbursed or cannot be reimbursed under any other health plan coverage.
- I take full responsibility for the accuracy and veracity of all the information I have provided.

_____ _____

Signature Date

(Please make copies of all documentation for your records before sending your claim form in.)