Benefit Solutions, Inc.

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HRA REIMBURSEMENT CLAIM FORM

Company Name: Alexander County Government

Employee Name: _____

Social Security #: _____

Employee Address: _____

Request for Medical Expense Reimbursement

Date Expense Incurred	Name of Service Provider (physician hospital, etc.)	Expense Description	Person for Whom Expense Incurred	Amount Requested
			TOTAL CLAIM $	

PLEASE ATTACH CORRESPONDING EXPLANATION OF BENEFITS (EOB)
YOU MUST INCLUDE COPIES OF YOUR BLUE CROSS EOB.

Employee Certification

I request payment from the reimbursement account for the expenses itemized above. I certify that I have not requested reimbursement under this plan or from any other source for these expenses. I further certify that I have met all the requirements for eligible medical expenses. I understand that reimbursed expenses cannot be claimed as a deduction on my personal income tax return.

Employee Signature _____ Date _____

Eligible Medical Expenses:

In general, you may be reimbursed for an expense for "medical care" (as defined in Internal Revenue Code section 213(d)) that has not and will not be reimbursed by any other source and has not and will not be deducted on your income tax return. Examples of eligible expenses include deductibles and co-insurance. If there is any question on items eligible for reimbursement, consult with your employer's human resources department for clarification.