Educators Benefit Consultants, LLC
Third Party Administrator

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Health Reimbursement Arrangement Claim Form

Name: _____ **SSN:** _____

Address: _____ **City:**_____ **State:**_____ **ZIP:**_____

Phone:_____ **Employer:**_____

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

Health Premium Costs				
Insurance	**Premium Amount/Monthly**	**Months Paid**	**Automatic Monthly Reimbursements (Circle)**	**Total**
Medical				
Dental				
Long Term Care				

- 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