FlexibleBenefit ADMINISTRATORS

Ph: 800-437-FLEX or 757-340-4567
P.O.Box 8188 • Virginia Beach, VA 23450
www.flex-admin.com

HRA Claim Form

How to File

Form can be submitted by (1) e-mail, (2) fax or (3) mail.

To submit by e-mail, Print Form and sign. E-mail form along with receipts to flexdivision@flex-admin.com

To submit by fax, Print Form and fax to: 757-431-1155

To submit by mail, Print Form and mail to: Flexible Benefit Administrators, Inc.
P.O.Box. 8188, Virginia Beach, VA 23450

Please:

- Do not mail your claim if you fax it.
- Keep a copy of all claim forms and receipts for your records.
- Notify Flexible Benefit Administrators, Inc. if you have a change in address.

Employee Information

Employee's

Print name

Social Security Number or Employee ID #

E-Mail address
(For Notification of Processed Claims, Reimbursement & Account Status)

Employer

Claims for Out-of-Pocket Expense

I, the participant, hereby file claim for the medical expense(s) noted below and certify that each expense was incurred on the date and for the person and reason noted. The expense(s) listed below was incurred for medical care not general health purposes and exclude cosmetic and/or toiletries expense(s). I, the participant, certify that I have not been reimbursed for the expense(s) noted below and that I will not seek reimbursement under any other plan covering health benefits. I, the participant, further certify that the expense(s) noted below have not been previously paid for by use of my Benefits Card. **Attached are receipts or bills as evidence of my expenses incurred during the Plan Year**.

	Person treated and Relationship	Type of Eligible Expense	Date of Treatment	$ Amount of Expense
1				$ 0
2				$ 0
3				$ 0
4				$ 0
5				$ 0
6				$ 0

Total $ 0

As a participant of the Plan, I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while I was covered under my employer's Health Reimbursement Arrangement Plan and that the expenses have not been reimbursed and reimbursement will not be sought from any other source. I fully understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense.

Employee's:

Signature

Date

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