105-HRA

Section 105 Health Reimbursement Arrangement (HRA) Claim Form

Mail or fax this form with documentation to:
Diversified Benefit Services, Inc.
P.O. Box 260
Hartland, WI 53029
Fax: (262) 367-5938
For additional claim forms log on at www.dbsbenefits.com

Employee Name (please print): _____

Email Address: _____ **Participant ID Number or Social Security Number:** _____

Name of Your Employer (please print): _____

Employee Signature: _____ **Date:** ____ / ____ / ____

Indicate here if your address/information has changed:

_____

_____

_____

If you are requesting reimbursement from a Section 105 Plan please complete the appropriate information at the right.

SECTION 105 HEALTH REIMBURSEMENT ARRANGEMENT (HRA)
SEE INSTRUCTION GUIDE IN REIMBURSEMENT KIT

Amount of reimbursement requested: $_____

Who incurred the expense?
(check all that apply)
- ❒ Employee
- ❒ Spouse
- ❒ Dependent

To expedite your Section 105 reimbursement please complete the top portion of the expense reimbursement claim form and remember to sign your name in the appropriate area.

You must attach proper documentation to this form for reimbursement. An example is an Explanation of Benefits (EOB) report from your medical insurance provider. This report is sent to you by your insurance provider *after* it has been processed.

OFFICE USE ONLY A: _____ D: _____

By signing this form, I certify that the amounts listed are correct and are expenses that represent qualified reimbursable expenses. I will not claim these items on my personal income tax return for medical itemization nor claim any dependent care reimbursement expenses as tax credit. I certify that I will not be reimbursed for the expenses listed below from any insurance company or insurance plan or the following: any other Flexible Benefit Plan, Medical Savings Account (MSA), Health Reimbursement Arrangement (HRA), Health Savings Account (HSA), another reimbursement plan or any other source. I also certify that the expenses have been incurred and dates of service are during the timeframe required by the benefit plan. I will also provide documentation necessary to support the amounts being requested for reimbursement.

Instruction Guide for Expense Reimbursement

105-HRA

Claim Form For Section 105
Health Reimbursement Arrangement (HRA)

Top Section of Claim Form:

1. Print your full name, email (if you have one), social security number and the name of your employer.
2. You must sign and date the claim form where indicated.

Bottom Section of Claim Form

If your claim is for the Section 105 Health Reimbursement. Account (HRA):

1. Go to Section 105-HRA area of the form.
2. Fill in total amount of reimbursement requested. Amount should be for the total cost of expenses incurred by you and/or your dependents while covered by a HRA.
3. Check all of the boxes that apply regarding who incurred the expenses. For example, if you as an employee incurred the expense, check the employee box. If you and your dependent have incurred expenses check both the employee and dependent boxes.
4. **Please attach copies (not originals)** of proper documentation to the expense reimbursement claim form. Documentation must show dates of service, your portion of the expense incurred and a description of the expense. An example of proper documentation includes an Explanation of Benefits Report (EOB) from your medical insurance provider. An EOB form documents service and is sent to you from your insurance company after you have received services by a physician, hospital or medical clinic. Other examples of proper documentation include a copy of your original invoice from a dental or vision provider showing the dates of service, services provided and the amount of the expense that is owed for the dental or vision services (if not covered by insurance.) Multiple pieces of documentation, may be attached to one reimbursement claim form. You do **not** need to complete separate reimbursement claim forms for each piece of documentation. **(If you have questions regarding your EOB report, please contact your insurance provider, not DBS, Inc.)**
5. When the claim form is completed follow the instructions found at the top right corner of the claim form to submit your claim to DBS, Inc.
6. If you have questions regarding your reimbursement, please refer to your summary plan description and/or other related plan information. (Ask your employer for a copy if you do not have one.) Or contact DBS, Inc.