Employee Benefits Group

Health Reimbursement Arrangement (HRA) Claim Form

Company: ______________________________

Employee Name: ______________________________

Home Address: ______________________________
Street City State Zip

Phone: ________________ **E-Mail:** ________________

NOTE: Federal law requires that you submit a written statement (such as an itemized bill from the benefit provider or an Explanation of Benefits (EOB) from an insurance carrier) as well as proof by signing below that the claim is not being reimbursed by other coverage. Also, you may not be entitled to claim any reimbursed expenses under an HRA as a tax deduction.

Date(s) of Service	Reason for Expense	Person Covered	Name of Service Provider	Amount
Example: 01/18/2008	*ER Visit; broken leg*	*Sally Jones*	*Elliot Hospital/Dr. Smith*	*$50.00*
			Total Submitted: $	

Read Carefully:

The above is a true and accurate statement of expenses allowed under my Company's HRA Plan for myself and covered family members, if enrolled. I attest that this claim is not being reimbursed by any other insurance coverage, and I am fully aware of the fact that I will not be entitled to claim any reimbursed expenses as a tax deduction.

Signature: ______________________________ **Date:** ________________

Send claims to: **CGI Employee Benefits Group**
Claims Processing Department
171 Londonderry Turnpike
Hooksett, NH 03106

Or Fax claims to: **603-232-9363**
Or E-mail to: **claims@cgibenefitsgroup.com**

For CGI Use Only:

Claim received: ________________ Processed by: ________________

Amount of payment: ________________ Payment date: ________________

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