# 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* |
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| | | | 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 Business Solutions**
**Claims Processing Department**
**5 Dartmouth Drive**
**Auburn, NH 03032**

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

**For CGI Use Only:**

Claim received: __________________ Processed by: __________________

Amount of payment: __________________ Payment date: __________________