All claims must be in our office **5 working days** prior to your scheduled check run.

HRA Claim Form

EMPLOYEE PROFILE

EMPLOYEE NAME: _____ SOCIAL SECURITY #: _____

MEDICAL REIMBURSEMENT

Expenses must be submitted to your medical plan first. Please complete the request below and attach a copy of your Explanation of Benefits (EOB) to this form and retain copies for your records.

AMOUNT REQUESTED	DATES OF SERVICE	
$	FROM	TO
$	FROM	TO
$	FROM	TO
$	FROM	TO

$ **TOTAL AMOUNT REQUESTED**

AUTHORIZATION

I certify that this information is correct, complete and meets all requirements for eligible health care expenses under the HRA Plan.

EMPLOYEE SIGNATURE _____ DATE _____

COMPANY NAME _____ GROUP NUMBER _____

CLAIMS ADDRESS

PO BOX 1349 WAKE FOREST, NC 27588
ATTN: CONSUMER ACCOUNTS DEPARTMENT
PHONE: 919-877-9933 EXT 5052 FAX:919-562-0021