

TAXSAVER PLAN

Health Reimbursement Arrangement (HRA) Claim Form

Name of Employer

Employee Last Name

First Name (please print)

Social Security Number

Patient Name (if other than Employee)

Date of Birth

Relationship to Employee

I have incurred the following expenses that qualify for reimbursement under the provisions of this Plan:

Health Care Expenses

\$ _____

I further testify that I have attached records necessary to substantiate these expenses. I understand that since these expenses are reimbursed through my HRA account that they may not be claimed on any federal income tax deduction or credit at year end. I further certify that I will not submit these expenses for payment by a third party, such as my major medical plan, or any other health plan, such as an individual policy or my spouse's or dependents health plan. If I elected a Health FSA, I understand the parameters of my Plan will require that I exhaust the HRA or FSA first before accessing the other account. Please refer to your Plan guidelines for details.

Date

Employee Signature

Documentation Required:

- 1) Health Plan receipts (Explanation of Benefits) sent from your health plan provider that substantiate deductibles, co-pays, co-insurance or other expenses not covered by a health plan.
- 2) Itemized receipts from health care providers that substantiate the date of service, type of service cost of service and the name and phone number of the provider.

Submit Claim To: Taxsaver Plan

HRA

P.O. Box 609002

Dallas, Texas 75360

800-328-4337 – www.taxsaverplan.com

214-528-8122 Fax

Claims@taxsaverplan.com – please attach jpg, tiff or jiff files

www.taxsaverplan.com