



3125 Airport Parkway, Cambridge, MN 55008
 Metro: 763-552-6053 Toll Free: 888-507-6053 Fax: 763-552-6055
 www.ebcsolutions.com

Health Reimbursement Arrangement Claim Form

Name: _____ SSN: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Employer: _____

Health Out-of Pocket Costs (Effective 1-1-2011 over-the-counter drugs and medicines are not reimbursable without a prescription from your doctor)								
Service Provided By	Date Incurred	Office Visit	RX	Dental	Vision	OTC Drugs	Other, Please specify	Amount Incurred
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
<i>Attach appropriate receipts.</i>				Total Health Care Expense Claim				

Health Premium Costs (please attach copy of your most recent health insurance premium invoice)					
Insurance	Premium Amount/Monthly	Months Paid	Automatic Monthly Reimbursements (Circle)		Total
Medical			Yes	No	
Dental			Yes	No	
Vision			Yes	No	

- I certify that all expenses for which reimbursement is claimed by submission of this form were incurred by me or my spouse, or dependent(s).
- I certify that the medical expenses incurred by me or my dependents are qualifying expenses as defined by the Internal Revenue Service Code. If these expenses are not qualified expenses I understand that I will be liable for payment of all related taxes on all ineligible amounts paid out by the Plan.
- I certify that the health expenses claimed have not been reimbursed or cannot be reimbursed under any other health plan coverage.
- I take full responsibility for the accuracy and veracity of all the information I have provided.

Signature

Date