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
		○	○	○	○	○		
		○	○	○	○	○		
		○	○	○	○	○		
		○	○	○	○	○		
Attach appropriate receipts.				**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