

# REQUEST FOR REIMBURSEMENT

## Health Reimbursement Arrangement

Fill out form, and mail (or fax) to address shown below

Employer:	Employee Name:	Social Security Number:
Employee Address:		

Expenses Incurred for:

Name: _____ <b>1. Relationship to Employee:</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <b>2. Type of Service (Check one):</b>  Health Care – Medical <input type="checkbox"/> Coinsurance <input type="checkbox"/> Deductible <b>3. Provider of Service:</b> _____ _____ <b>4. Date(s) of Service:</b> From _____ to _____ <b>5. Amount to be Reimbursed:</b> \$ _____ <b>6. Proof of Expense*:</b> (attach copy of) <input type="checkbox"/> Explanation of Benefit form	Name: _____ <b>1. Relationship to Employee:</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <b>2. Type of Service (Check one):</b>  Health Care – Medical <input type="checkbox"/> Coinsurance <input type="checkbox"/> Deductible <b>3. Provider of Service:</b> _____ _____ <b>4. Date(s) of Service:</b> From _____ to _____ <b>5. Amount to be Reimbursed:</b> \$ _____ <b>6. Proof of Expense*:</b> (attach copy of) <input type="checkbox"/> Explanation of Benefit form	Name: _____ <b>1. Relationship to Employee:</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <b>2. Type of Service (Check one):</b>  Health Care – Medical <input type="checkbox"/> Coinsurance <input type="checkbox"/> Deductible <b>3. Provider of Service:</b> _____ _____ <b>4. Date(s) of Service:</b> From _____ to _____ <b>5. Amount to be Reimbursed:</b> \$ _____ <b>6. Proof of Expense*:</b> (attach copy of) <input type="checkbox"/> Explanation of Benefit form
---	---	---

***\*Always retain copies of any proof of expense submitted with this Request for Reimbursement.***

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred by the named person(s). I certify that these expenses have not been and will not be reimbursed under any other employer sponsored benefit plan, and will not be claimed as an income tax deduction. Also, I certify that these expenses have not been previously reimbursed under this plan.

I authorize that my Plan Account may be reduced by the amount of the reimbursement listed above.

Employee's Signature:	Date
-----------------------	------

Please return your Request for Reimbursement and proof of expense to:

Centurion Corporation	(603) 643-2000
PO Box 959	(800) 258-3056
Hanover, NH 03755	(603) 643-2740 fax



## Instructions for Submitting Requests For Reimbursements

- You can submit requests for reimbursements for eligible medical expenses that will not be reimbursed by any other employer sponsored benefit plan and which would qualify as a deduction on your income tax return.
- Expenses must be incurred during your Plan year.

### **To submit a Request for Reimbursement:**

- Complete all applicable items on the reverse side.
- Submit with this form, proof of your expenses - an Explanation of Benefits [EOB] from your insurer.
- Requests for reimbursements can be made at any time as long as the accumulated expenses equal or exceed \$25. Medical reimbursement requests can not exceed your total annualized contributions.
  1. Requests for reimbursement can be made up to three months beyond the end of the Plan year.
  2. Requests for reimbursement for expenses totaling less than \$25 may be submitted at the end of the plan year or during the run-off period.
  3. Requests can be submitted up to the 20th of each month, and will be mailed on the 25th of each month. Requests for urgent care claims will be processed upon receipt.
- Reimbursements are not assignable and will be made to the provider.
- Return your Requests for Reimbursement and proof of expense to:

**Centurion Corporation**  
Reimbursement Administrator  
Centurion Place, Hanover Road  
PO Box 959  
Hanover, NH 03755-0959  
[flex@centurionusa.com](mailto:flex@centurionusa.com)

If you have any questions regarding your reimbursements, please contact the Reimbursement Administrator, by phoning (603) 643-2000 or (800) 258-3056.

H:\DATA\FLEX.DOC\Common & Upload PDF forms\Centurion Designed Master Blank Documents\Request\_for\_HRA\_reimbursement.doc

