# HRA & FSA Claim Form

Complete this form to receive reimbursement from your Health Reimbursement Arrangement (HRA) and/or Flexible Spending Account (FSA). You MUST attach a(n) receipt/Explanation of Benefits (EOB) to receive reimbursement. If you are not in the Flexible Spending Account, please disregard the right section of the claim form entitled "Flexible Spending Account". If you are in the Flexible Spending Account and are filing a Health Reimbursement Arrangement claim and would like to be reimbursed from the FSA for expenses you are responsible for paying, please indicate this on the left side of the claim form entitled "Health Reimbursement Arrangement" under the column entitled "Reimburse your portion from FSA". If you mark yes (Y), we will determine the amount of the claim that is due from the HRA and the amount that is due from the FSA.

## Employee/Participant Information

**Employee/ Participant Name** _____ **Employee Social Security #** _____ **Employer/ Company Name** _____

☐ Change of Address **Home Address** _____ **City, State Zip** _____

**Email Address** _____ **Contact Phone** _____

## Health Reimbursement Arrangement

| Date Incurred | Description of Expense | Name of Family Member | Relationship to Employee | FSA debit card used? | Expense Amount | Reimburse your portion from FSA? |
|---|---|---|---|---|---|---|
| | | | Self | Y N | $ 123.00 | Y N |
| | | | Self | Y N | $ | Y N |
| | | | Self | Y N | $ | Y N |
| | | | Other | Y N | $ | Y N |
| | | | Self | Y N | $ | Y N |
| | | | Self | Y N | $ | Y N |
| | | | Self | Y N | $ | Y N |
| | | | Self | Y N | $ | Y N |
| | | | | Total | $ 123.00 | |

## Flexible Spending Account

| Date Incurred | Type of Expense* | Description of Expense | Name of Family Member | Relationship to Employee | FSA debit card used? | Expense Amount |
|---|---|---|---|---|---|---|
| | H D | | | Self | Y N | $ 123.00 |
| | H D | | | Self | Y N | $ |
| | H D | | | Self | Y N | $ |
| | H D | | | Self | Y N | $ |
| | H D | | | Self | Y N | $ |
| | H D | | | Self | Y N | $ |
| | H D | | | Self | Y N | $ |
| | H D | | | Self | Y N | $ |
| | | | | | Total | $ 123.00 |

*H = health care expense (dental, vision, prescription, etc)
D = dependent care expense (daycare).
Submission of daycare expenses require Dependent Care Verification on file

## Authorization

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's cafeteria plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense. If a fraudulent claim is filed, you will be responsible for paying back the fraudulent claim.

**Signature** ☐ By checking the box to the left I agree to the terms above. **Date** _____ **Print Name** _____

To submit:
- Fax form and documentationto (866)209-3517
- Scan and email documentation to flexpak@swerdlin.net
- Mail to Swerdlin & Company, 5901 Peachtree Dunwoody Road, B-100, Atlanta, GA 30328

For questions, please email flexpak@swerdlin.net or call (866)353-9725. For balance inquiries, please visit www.flexpakcafe.net