Please complete when faxing your claim:

Date: _____

# of Pages: _____

Return Fax #: _____

Please print clearly. Thank you!

Health Reimbursement Account (HRA) Program

Claim Form

To request reimbursement, please complete this form, including appropriate documentation and provide signatures where required.

Employee Name _____ Employee Social Security # _____

Employer _____ Daytime Telephone _____ Check here if this is a change of address: ☐

Home Address _____

City _____ State _____ ZIP Code _____

Health Reimbursement Account

Service Date	Name of Service Provider	Name of Family Member for whom Reimbursement is Requested & Relationship	Date of Birth	Medical Deductible or Copayment amount	Amount Requested for Reimbursement
					$
					$
					$
					$
					$
					$
					$
					$

WILL ANY OF THE ABOVE EXPENSES BE COVERED OR REIMBURSED FROM ANY OTHER SOURCE (e.g. Blue Cross, an HMO or another Employer's Insurance Plan) ? ☐ **NO** ☐ **YES** If yes, you must attach copies of the other plan's explanation of benefits form.

I have read the Summary Plan Description Reimbursement Plan and certify that the expenses listed above meet all requirements as qualified expenses.

Participant's Signature _____ **Date** _____

Submit Reimbursement requests to :

Activa Benefit Services, LLC
P.O. Box 37
Farmington, MI 48332

Fax: (616) 588-7915
Phone: (877) 827-1414 or (616) 588-5340