first CONCORD
Benefits Group

www.firstconcord.com
P.O. Box 67220
Lincoln, NE 68506

Phone: 402-423-4454
Fax: 402-423-4549

# HRA/Deductible Buy Down Claim Form

*Please attach all required documentation*

Dear Employee:

You will find below First Concord Benefits Group's policy on reimbursement for expenses from the Health Reimbursement Account.

In order to be reimbursed from the HRA, the expenses must not be eligible for payment from any other third party (i.e. health or dental insurance). The information listed below must be provided:

- A First Concord Benefit Group claim form signed by the employee.
- An insurance company Explanation of Benefits form or a bill (or copy of a bill) that contains the following information:
  - Provider's name
  - Date of service
  - Person for whom the service was performed
  - A brief description of the services performed
  - Amount charged

Most insurance company Explanation of Benefit forms contain this information. Bills you receive from your provider and prescription receipts also contain this information.

*We cannot accept statements where the only information provided is a "balance due" or "received on account". These statements lack several key pieces of information.*

Thank you for your cooperation. If you should have any questions, please feel free to call our offices.

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*Please attach all required documentation*

| Employer: | |
|---|---|
| Employee Name: | Social Security Number: |

## Health Reimbursement Account:

| Dates of Services (Month/Day/Year) | Name and Address of Service Provider | Dollar Amount |
|---|---|---|
| | | $ 0.00 |
| | | $ 0.00 |
| | | $ 0.00 |
| | | $ 0.00 |
| | | $ 0.00 |
| | TOTAL AMOUNT PAID | $ 0.00 |

***Please Read Carefully – Do Not Forget to Attach Required Documentation***

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 HRA Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other plan. 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, and city income tax on amounts paid from the Plan which related to such expense.

Employee Signature _____ Date _____