

HRA Plan Claim Form (for HRA claims only)

Personal Information	Employee Name	Company Name									
	Home Address	Address Change <input type="checkbox"/> Yes <input type="checkbox"/> No									
	Social Security Number <table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> </tr> </table>										

For Quick Claim Processing: <ul style="list-style-type: none"> ▶ Fully Complete & Sign this Claim Form ▶ Attach a copy of supporting receipts, vouchers, bills, etc. ▶ All receipts must detail each of the items summarized below ▶ Please print when using this form ▶ Minimum Total Reimbursement \$25 	For Account Balance: Go To www.NBSbenefits.com Or Call (801) 838-7324 or (888) 353-9125 <small>Please allow 48 hours for claims to be processed</small>
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HRA Claims	Date of Service			Provider	Service Rendered	Person Receiving Service	Amount		
	Mo	Day	Yr				\$	¢	
<small>(The total must be at least \$25 for claim payout) Total Health Care Expenses</small>									

Eligible Expenses	<ul style="list-style-type: none"> ● Please review your Summary Plan Description (SPD) for a list of eligible expenses.
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Employee Signature	I, the undersigned, attest that to the best of my knowledge these statements are complete and true. I authorize the release of any medical information to my spouse. I certify these expenses are for valid services provided on the dates indicated and will not be reimbursed or claimed under any other Plan, claimed as a Tax Deduction or Tax Credit.	
	Employee Signature X	Date

NBS - 402(10/07)

Please fax or mail your claim form and receipts to the following:

Mail: National Benefit Services, LLC P.O. Box 6980, West Jordan, UT 84084
FAX: Salt Lake City Area Fax: (801) 355-0928 Toll Free Fax: (800) 478-1528
Email: claims@NBSbenefits.com (PDF, TIFF or JPEG files only)