Health Reimbursement Account (HRA) Claim Form

Complete this claim form in its entirety, provide legible documentation as instructed, and sign below. Please print clearly.

Your Name (Last, First, MI)	Social Security No. or EID or PIN	Your Employer Name
		Vassar College

Address	City	State	Zip Code

Health Reimbursement Account Claims

Please include appropriate documentation required by your employer plan with this completed claim form as follows:
If covered by insurance, provide the insurance payer's Explanation of Benefits Statement. If not covered by insurance, provide an itemized statement from the provider of care. An itemized statement must include the provider name/address, patient name, description of the type of service provided, date the service was provided (not when you paid or were billed), and the dollar amount. Prescriptions require the pharmacy receipt, pharmacy printout, or the mail-order itemized statement.

Note: Examples of unacceptable documentation include cancelled checks, credit card receipts, balance forward/amount due/paid-on-account statements, pre-treatment estimates or statements for future dates of service.

Date(s) of Service	Health Care Provider	Description of Expense	Patient Name	Relationship to You	Amount Requested	ASIFlex Use Only
					$	
					$	
					$	
					$	
					$	
					$	
					$	
				TOTAL	**$**	

I certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred by me, an eligible spouse, or an eligible dependent during a period while I was covered under my employer's HRA Plan and that the expenses have not been reimbursed and reimbursement will not be sought from any other source.

I understand that I am fully responsible for the accuracy of all information relating to this claim, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan which relate to such expense. A claim will only be processed with a completed and signed claim form and correct documentation.

SIGN HERE → → Employee Signature _____ Date _____

FAX TO:
1-877-879-9038
PAGE _____ OF _____
NO COVER PAGE REQUIRED

MAIL TO:
ASI
PO BOX 6044
COLUMBIA, MO 65205-6044

QUESTIONS:
WWW.ASIFLEX.COM
ASI@ASIFLEX.COM

Vassar College has contracted with ASIFlex to administer their Health Reimbursement Accounts. ASI issues reimbursements for eligible expenses and can also provide you with a debit card you can use to pay for your expenses directly. The money in the account is not taxable to the retiree, provided it is used for qualified medical expenses, per IRS rules.

Claim Filing Requirements

1. ***Print your name, address, social security number or employee ID (EID) as appropriate and your employer's name.***

2. ***List expenses by date & arrange the supporting statements in the same order.*** Highlight or circle the service dates on your documentation.

3. ***Enclose the Explanation of Benefits statement you received from your insurance provider***. Submit an EOB or other detailed billing statement to receive reimbursement.

4. ***Sign*** the claim form.

5. ***Keep*** copies for your tax records.

6. ***Mail*** to the address on the front of this form or ***Fax to (877) 879-9038***. This is a toll-free number but employee use of an office fax machine may not be appropriate. Please check with your employer before using an office fax machine.

7. ***In order to be reimbursed for insurance premiums***, please send an itemized statement from your insurance carrier (must include dates of your premium coverage period, type of insurance, premium amount and proof of payment). Proof of payment may be provided in the form of pay stub, bank statement, copy of cancelled check, credit card receipt, or electronic payments. Premiums with future dates will not be processed.

Please contact ASIFlex with questions at (800) 659-3035, or via email asi@asiflex.com.