

Please fax or mail completed request to:

HRA CLAIM FORM

McGregor & Associates, Inc.
333 West Vine Street, Suite 1610
Lexington, KY 40507
(866) 233-4377 Toll Free
(859) 255-2999 Fax

Employee Information

Employer: _____
Employee: _____ SSN: _____
Address: _____ Email: _____
City: _____ State: _____ Zip Code: _____

EOBs for Proof of Deductible (necessary only for Plans in which an HRA Deductible applies)

In order to access your HRA funds, you must first submit EOBs reporting that you have met your HRA Deductible. **Note:** Expenses in this section will not be reimbursed; you must first meet your HRA Deductible before accessing your HRA Account.

Service Date	Claimant Name	Type of Service	Provider Name	Amount
<i>Total Applied to Deductible</i>				\$

Receipts for Reimbursement

Please complete this section for reimbursement requests from your HRA Account. You must provide a corresponding receipt and/or EOB to substantiate the claim. **Note:** You may have to meet your HRA Deductible before you are eligible for reimbursement. Consult your HR Department or McGregor & Associates, Inc. for more information about your Plan.

Service Date	Claimant Name	Type of Service	Provider Name	Amount

Do you want reimbursement made via direct deposit? *Total Amount for Reimbursement* \$
 Yes No (to sign up for direct deposit, please contact McGregor & Associates, Inc.)

Agreement and Signature*

I certify that these expenses have been incurred by me or my eligible dependent and are not for cosmetic purposes, but for treatment of an illness, injury, trauma or medical condition. I understand that the term "incurred" is defined as the date the service was provided that gave rise to the expense regardless of when I am billed/charged or pay for the service. The expenses have not been reimbursed and I will not seek reimbursement elsewhere. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax return. I understand that I am not eligible for reimbursement until I have reached the HRA Deductible set by my Employer. I have received and read the Summary Plan Description applicable to this Plan and understand the provisions.

Signature: _____ Date: _____

*This Form *must* be submitted with proper documentation. Claims without proper documentation or signature will not be processed.