Health Reimbursement Arrangement Claim Form

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Employee Name		Social Security #	
Phone		Email	

UNREIMBURSED MEDICAL EXPENSE CLAIMS

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
Please attach receipts & submit with claim form			Total $	$0.00

READ CAREFULLY

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

Employee's Signature (required)	**Date**

Submit Claims to:
PB&H Benefits, LLC
Attn: Flexible Benefits Director
401 W. Hwy 6
P.O. Box 20725
Waco, TX 76702-0725
Fax: (254) 772-0455
E-mail: dmoon@pbhcpa.com

Questions?
Please call:
(254) 741-6688 Local
(888) 629-2363 Toll Free
Or visit us at:
www.pbhbenefits.com

PB&H BENEFITS