HRA
CLAIM FORM

EMPLOYEE INFORMATION (Please Print)			☐ **Check here if address has changed**
Participant Name		SSN	
Mailing Address	City	State	Zip
Date of Hire		Date of Birth	
Email		Day Phone	
Employer BURNET COUNTY			

UNREIMBURSED MEDICAL EXPENSES (Attach supporting documentation)

Does your receipt include **all** of the following?

☐ *Provider's name* ☐ *Provider's address*
☐ *Service provided* ☐ *Amount billed*
☐ *Actual date(s) of service: Date of payment is not sufficient*

Person for Whom Expense was Incurred	Date of Service	Name of Service Provider	Description of Services	Amount
SEE ATTACHED EOB(S)				
		Total Unreimbursed Medical Expenses		

READ CAREFULLY

The above is a true and accurate statement of all expenses incurred by myself or my eligible dependents on the date(s) indicated, and were incurred while I was covered under the HRA, and that I have not been reimbursed previously under the Plan or any other health plan, nor do I expect any of these expenses to be reimbursable elsewhere. Supporting documentation from my service provider(s) for all expenses are attached to this claim form. I understand that I cannot claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax on the amounts paid for any expense improperly claimed under the provisions of the HRA.

Participant Signature _____ Date _____

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HUMAN RESOURCES DEPARTMENT