

HRA REIMBURSEMENT REQUEST FORM

This form allows you to request reimbursement for eligible health items, outlined in your employers plan documents.

INSTRUCTIONS: INCLUDE RECEIPTS AND DOCUMENTATION WITH THIS REQUEST FORM

- Complete** all applicable sections of this form. **Remember to sign and date the bottom of this form.**
- Attach** this completed form and supporting documentation to Igoe Administrative Services for review via:
 - All itemized bills
 - Explanation of Benefits
 - Statement of service
 - Receipts for expenses incurred

Please Note: All supporting documents become a part of this claim and **will not** be returned.
- Submit** this completed form and supporting documentation to Igoe Administrative Services for review via:
 - Secure Upload through your personal account at www.goigoe.com
 - Email to flex@goigoe.com
 - Fax to 800-456-9083 Please make sure to properly dial the fax number listed on this form. Igoe accepts no responsibility for transmissions that are routed to the wrong location based on dialer error.
 - OR Mail to Igoe Administrative Services, P.O. Box 501480, San Diego, CA 92150-1480
- Questions?** Please contact Participant Services at flex@goigoe.com, 1-800-633-8818, Opt# 1.

Section A: About You *(All information is REQUIRED. Please print clearly)

Employer Name _____

Participant Name _____

Number of pages _____

Employee Number (if Applicable) _____

Home Address Please check if this is a change in address _____

City _____

State _____

Zip _____

E-mail Address _____

Phone Number _____

Section B: HRA Expenses Incurred (for participant and all federal tax dependents)

SERVICE DATE (mm/dd/yy)	NAME OF DOCTOR / PROVIDER OF SERVICES	DESCRIPTION OF EXPENSE	PERSON INCURRING EXPENSE NAME, AGE, RELATIONSHIP	NET AMOUNT
				\$
				\$
				\$
				\$
Total Amount				\$

Please Attach Explanation of Benefits From Carrier

Section C: Authorization *REQUIRED (PLEASE SIGN AND DATE)

As a participant in the Plan, I certify that all above expenses were incurred during the Plan Year while I was covered under the Flexible Benefit Plan and that the expenses have not been or are not being reimbursed under any other benefit plan or charged to my employer's Flexible Benefits Card (if applicable). I understand that I am fully responsible for the sufficiency, accuracy, and validity of all information relating to this request. I further acknowledge that each expense for which payment or reimbursement is requested must be a proper expense under the Plan. If not, I understand that I may be liable for the payment of all related taxes including Federal, State or City Income Tax on amounts reimbursed. I further understand that **NO TAX DEDUCTION IS PERMITTED FOR AMOUNTS FOR WHICH REIMBURSEMENT IS MADE.** Having agreed to all of the proceeding statements, I authorize the Flexible Benefit Plan Account/s in my name to be reduced by the amount requested and reimbursed to me according to my employer's reimbursement schedule and method.

Participant's Signature: _____ Date: _____