PROFICIENT™
BENEFIT SOLUTIONS

Health Reimbursement Arrangement Claim Form

##11SAS001##########

We *care* about your experience and want to ensure you have the information you need to submit your HRA claim accurately the first time! Mail or fax your completed form to:

Proficient Benefit Solutions
P O Box 380768
San Antonio, TX 78268
FAX: (210) 659 - 8171

SECTION 1: EMPLOYEE INFORMATION (Please Print)

Name:_____ SSN:_____

Address:_____ Phone:_____

City, State, Zip: _____

Employer: _____

Email Address: _____

(Your email address may be used for contact if additional information is required and we are unable to reach you by phone.)

SECTION 2: HEALTH REIMBURSEMENT ARRANGEMENT (Attach Explanation of Benefits)

An EOB MUST be provided which shows the date of service and the eligible amounts applied to your deductible. Proficient Benefit Solutions will only process reimbursement for expenses with a supporting EOB and for those expenses you are claiming on this claim form. Incomplete claims will be denied.

Person for Whom Expense was Incurred	Date of Service	Name of Provider	Description of Service	Amount
1.				
2.				
3.				
4.				
			Total Unreimbursed Deductible Expenses	

SECTION 3: EMPLOYEE CERTIFICATION

I certify that all expenses requested to be reimbursed comply with my employer's Health Reimbursement Arrangement Plan and such expenses have not and will not be covered under any other plan or program of any employer or other person. I further certify that if such expenses are reimbursed to me by a provider or any other entity, I will promptly reimburse the Plan. The Plan Administrator does not accept responsibility for direct payment to any individuals other than the employee.

_____ _____

Employee Signature Date