HRA CLAIM FORM

Employer:	**Health Reimbursement Arrangement (HRA)**
Employee Name:	S.S.# ☐☐☐-☐☐-☐☐☐☐
Address:	
City: State: Zip:	Email Address:
☐ check if new address	Day Phone:

CLAIM DETAIL

Date of Service:	Who received service:	Type of Service:	Amount:
☐☐-☐☐-☐☐			$☐☐☐☐.☐☐
☐☐-☐☐-☐☐			$☐☐☐☐.☐☐
☐☐-☐☐-☐☐			$☐☐☐☐.☐☐
☐☐-☐☐-☐☐			$☐☐☐☐.☐☐

►Please review the Summary Plan Description (SPD) for what is covered by your Plan.
► Minimum Claim: $25

I understand that if I claim these expenses here, that I may not claim the same expenses elsewhere, or as tax credit or tax deduction. I understand the minimum claim check mailed is $25.

I certify that to the best of my knowledge these statements are complete and true. I authorize the release of any medical information to my spouse and to Ben-X, LLC using the above email address for communication regarding my claim informaton.

Sign Here _____ Date_____

Participant Signature

Completed forms and all required receipts may be Faxed, E-mailed or Mailed to Ben-X,LLC

Fax: Send via Fax for Faster Claim Processing! (801) 852-8797 (use this form as the cover page)
Email: Claims@BenXco.com
Mail to: Claims at Ben X, LLC • 5406 W 11000 N • Ste. 103-432. Highland • UT • 84003
Questions? Email: support@benxco.com

Rev 10.01

Print Form Clear Form