**HEALTH REIMBURSEMENT ACCOUNT (HRA)** Muncie Community Schools

**REQUEST FOR REIMBURSEMENT**

**EMPLOYEE NAME:** _____

**12 DIGIT NUMBER FROM ID CARD:** _____

**ADDRESS:** _____ ☐ **INDICATE IF NEW ADDRESS**

_____

**REQUEST TYPE:** ☐ **CURRENT YEAR MEDICAL EXPENSES**

☐ **ROLLOVER MEDICAL EXPENSES**

| **DESCRIPTION OF EXPENSE -** *Proof of Incurred Expense* | **AMOUNT OF EXPENSE** |
|---|---|
| **1** | **$** |
| **2** | **$** |
| **3** | **$** |
| **4** | **$** |
| **5** | **$** |
| **6** | **$** |
| **7** | **$** |
| **8** | **$** |
| TOTAL | **$** |

To the best of my knowledge and belief, my statements in this Request For Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been, nor will be , reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my Health Reimbursement Account to be reduced by the amount requested.

**SIGNATURE:** _____

**DATE:** _____

**MAIL OR FAX THIS CLAIM FORM WITH ATTACHED PROOF OF PAYMENT TO:**

Unified group services

P.O. Box 10
Pendleton , IN 46064

Phone : (800) 291-5837
Fax: (765) 608-6689