FlexSource, LLC – HRA Reimbursement Form

Employer: _____ Date: _____

Employee Name: _____

Please complete this Form in its entirety and attach a copy of the Explanation of Benefits (EOB) from the insurance provider. You must specify the insured individual, date of service and the dollar amount on the EOB for each occurrence.

Patient	Date of Service	Dollar Amount

I certify the information here is true and correct. I am claiming reimbursement only for eligible expenses incurred during the current plan year and for eligible plan participants. These expenses have not been previously reimbursed under this plan or other benefit plans and will not be claimed as a deduction on my income tax. I authorize my HRA to be reduced by the amount(s) requested.

Employee Signature: _____ Date: _____

Mail or Fax Request for Reimbursement to:

FlexSource, LLC
894 Euclid Ave.
Elmhurst, IL 60126
P: (630) 782-0633 ***F: (630) 782-0644***