BeneFLEX HR RESOURCES INC.

Antonia Fire Protection District

Claim form valid for claims Incurred 1/1/14 – 9/30/14

Please Check HRA Plan You Are Submitting

□ **Employee Only $3,000 Deductible**
1st $1,500 paid by Employee
2nd $1,500 paid by Employer

□ **Employee Plus One $6,000 Deductible**
1st $1,500 pd by EE for each family member
2nd $1,500 pd by ER for each family member

□ **Family Coverage $9,000 Deductible**
1st $1,500 pd by EE for each family member
2nd $1,500 pd by ER for each family member
(Max 3 Family Members to meet Family Deductible)

Note: The HRA does not reimburse out-of-network claims.

EMPLOYEE INFORMATION

Name: _____ Social Security#: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Address: _____ Company Name: Antonia Fire Protection District

City/State/Zip: _____

Date of Birth: _____ Gender: _____ Daytime Phone Number: _____

☐ **Please check box if address is new**

Detail of Request

Date of Service (Must be Itemized)	Name of Service Provider	Expense Description	Person for whom the expense was incurred	Please identify as in-network $ or Out-of-network $
	Total Amount Requested:		→	

Please attach (EOB) Explanation of Benefits in order listed above.

The undersigned participant in the Plan certifies all expenses for which reimbursement or payment is claimed were incurred during the current period under the company's HRA Plan. The undersigned fully understands he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all the information relating to this claim.

_____ _____

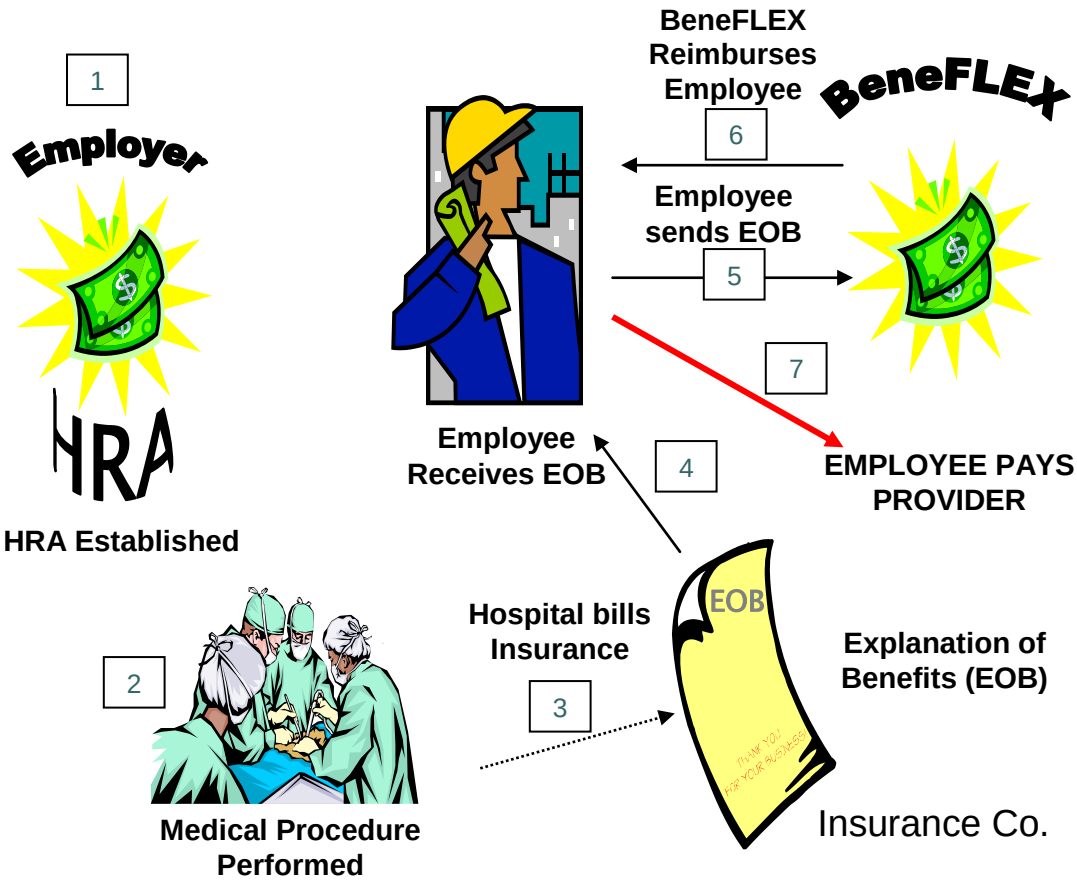
Employee's Signature (must be signed for proper processing) Date

BeneFLEX HR Resources Inc.
10805 Sunset Office Dr., Suite 401
St. Louis, MO 63127
314-909-6983 (fax)
314-909-6979 (phone)

FAX or MAIL (we prefer fax)
ALONG WITH SUPPORTING
DOCUMENTATION
http://www.beneflexhr.com

- To be reimbursed, **<u>you must submit your</u>** (EOB) **<u>Explanation of Benefits</u>** from your insurance co.

HRA Example in a Nutshell



1 - Employer sets up an HRA – a promise to reimburse a portion of the deductible.
2 - Participant has a qualifying medical event.
3 - Carrier receives medical bill and creates the EOB.
4 - Carrier sends EOB to participant.
5 - Participant sends claim form and EOB to BeneFLEX.
6 - Participant receives reimbursement from BeneFLEX.
7 - Participant pays the provider.

Facts for Your Reference

- BeneFLEX fax number -- (314) 909-6983
- BeneFLEX phone numbers -- (314) 909-6979 and (800) 631-3539
- If you terminate employment, any expenses **incurred** after your termination date are not eligible for reimbursement. Medical Expenses can still be claimed if you continue your participation under COBRA.
- All claims must be signed and dated.
- You may fax, mail or submit your claim through the Employee portal via our website, www.beneflexhr.com.
- If you fax your claim, keep a copy of the confirmation statement in case BeneFLEX does not receive your paperwork.
- Please itemize each (EOB) Explanation of Benefits on your claim form.
- You can contact BeneFLEX HR Resources, Inc. by e-mail at info@beneflexhr.com or visit our web page at www.beneflexhr.com.
- To ensure reimbursement in a timely manner, BeneFLEX HR Resources, Inc. must receive all claims no later than 3:00 p.m. (central) on Monday for weekly processing.