Health Reimbursement Account

Claim Reimbursement Form

Employer: _____ ***Plan Year:*** _____

Participant: _____ ***Last Four of SSN:*** ***XXX-XX-*** _____

Address: _____

City, State, Zip Code: _____

Phone: _____ ***Email:*** _____

Date of Service:	***Provider:***	***Amount:***
	Total Amount Requested $	

- ***All claims require an explanation of benefits (EOB) showing the date of service and provider.***
- ***Canceled checks, bank statements, and credit card receipts are not adequate.***
- ***Expenses must be incurred during the plan year noted at the top of this form. For terminated employees, claims must additionally be incurred prior to the date of termination of employment.***
- ***Reimbursements are issued weekly. Monday, checks will be mailed and Direct deposits will occur, for claims approved prior to Wednesday at 3pm (Central Time) of the preceding week.***

Certification

I, the undersigned, have incurred the expenses listed above that qualify for reimbursement under my employer's HRA plan. I have not been and will not be reimbursed for these expenses from any other source, including but not limited to, an insurance plan, this plan, or other programs that may be offered by my or my spouse's employer. I understand these expenses may no longer be claimed as deductions for income tax purposes. I acknowledge that I am solely liable for any taxes or penalties on ineligible expenses submitted through the health reimbursement account. I am responsible for the accuracy and validity of the submitted expenses and will retain substantiation. I hereby request reimbursement for these expenses and, if applicable, reaffirm the authorization provided to Cobra Professionals, Inc. to issue reimbursement via direct deposit to my bank account on file.

Participant Signature: _____ ***Date:*** _____

Completed claim forms and copies of EOBs may be faxed to (225) 706-0280 or scanned and emailed to cpisupport@mycpiteam.com. Please retain originals for your records.