Advantage™ ADMINISTRATORS

Health Reimbursement Arrangement (HRA) CLAIM FORM

(SUPPLEMENTAL REIMBURSEMENT PLAN)

Employee Name: _____ SSN #:_____

Change of Address: _____

Company Name: _____

Date of Service	Provider	Service Description	Patient	Dollar Amount

Important: **You must attach your Insurance Explanation of Benefits or prescription tags, if applicable to your claim for all expenses submitted.**

READ CAREFULLY: The undersigned plan participant certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period in which the undersigned was covered under the employer's plan with respect to such expenses and that the medical expenses have not been reimbursed and are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to his claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the plan, the undersigned may be liable for payment of all related taxes including federal, state, or local tax on amounts paid from the plan which relate to such expense.

_____

Participant's Signature Date

Please complete and return with proper attachments by:

Mail: PO Box 118 Waverly, IA 50677 **Fax:** 319-352-2610 or 319-352-4018 **E-Mail:** customercare@advantageadmin.com