

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) CLAIM FORM

for Franklin & Marshall College

To request reimbursement, please complete this Claim Form, attach appropriate documentation, sign and date. All required information applicable to your claim must be provided in order to process your claim. **Please return this completed form, plus documentation, to Significa Benefit Services.**

I certify that all expenses for which I have requested reimbursement: (a) have not been and will not be reimbursed by any other source, including any other health insurance plan, (b) were incurred by my eligible dependent(s) or me, and (c) are eligible for reimbursement per the terms of the Franklin & Marshall College Health Reimbursement Account Plan.

Employee's Signature

Date

(your signature is required in order to process this claim)

Employee's Name: _____ College ID #: _____
First Middle Last

Mailing Address: _____

Daytime Phone Number (w/ area code): _____

In order to receive reimbursement, copies of supporting documentation must be attached. Please include copies of your Explanation of Benefits (E.O.B.) from your insurance company listing service dates, service performed, and cost. Please retain a copy of this Claim Form and supporting documentation for your records, as Significa is unable to return original documents to you.

SERVICE DATE	DESCRIPTION	CLAIM TYPE	AMOUNT
		for High Deductible Health Plan deductible	\$
		for High Deductible Health Plan deductible	\$
		for High Deductible Health Plan deductible	\$
		for High Deductible Health Plan deductible	\$
		for High Deductible Health Plan deductible	\$
		for High Deductible Health Plan deductible	\$
		for High Deductible Health Plan deductible	\$
		TOTAL:	\$

Please mail or fax your completed, signed Claim Form plus required documentation to:

SIGNIFICA BENEFIT SERVICES, P. O. BOX 7777, LANCASTER, PA 17604-7777

PHONE: (717) 581-1300

1 (800) 433-3746

FAX: (717) 581-8379

www.significabenefits.com