

FLEX/HRA REIMBURSEMENT REQUEST

Employer: _____

Employee Name: _____

Address: _____

City, State, Zip: _____

Check here if new address Phone: _____ Email Address: _____

List your expenses for reimbursement below. Indicate if the charges should be processed through the HRA or your Flex plan by checking the line under those options. You can check both HRA and Flex.

Date of Service	Description of Service	Patient	Charge	Flex	HRA
_____	_____	_____	\$ _____	_____	_____
_____	_____	_____	\$ _____	_____	_____
_____	_____	_____	\$ _____	_____	_____
_____	_____	_____	\$ _____	_____	_____
_____	_____	_____	\$ _____	_____	_____
TOTAL:			\$ _____		

Please attach documentation of your expenses. For the HRA you must include the explanation of benefits from the insurance carrier showing charges being applied to the deductible or coinsurance of the health plan.

I certify that the above information is accurate and represents expenses I or my dependents have incurred. I further certify that these expenses have not been reimbursed by any other benefits that may be available.

Signature of Account Holder

Date



Send to:

P.O. Box 247
Onalaska, WI 54650
Phone: 608-779-3000 or 888-540-0094
Fax: 608-779-3009 or 877-540-0094
info@3PA.com

DEPENDENT CARE REIMBURSEMENT REQUEST

Dependent Care Reimbursement (Day Care Expenses)

Dates of Coverage		Name of Dependent(s)	Name and Tax Identification Number Of Child Care Provider	Amount Paid
From	To			
TOTAL	Attach a detailed receipt or you may have the provider sign this form instead. Provider Signature:			

This is to certify that my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my Flexible Compensation Account to be reduced by the amount requested.

Participant's Signature

Date



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