

HRA

Reimbursement Claim Form

Kabel Business Services
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For Account Inquiries Visit our web site at
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Employer: 2010 Episcopal Diocese of Iowa

Employee Name:

Social Security Number:

New Address:

Phone:

HRA Deductible/Co-insurance Expense Claims

I have single coverage under the group health plan with a \$900.00 deductible and \$3,600.00 out-of-pocket maximum

I understand that I cannot submit claims to this account until I have paid the first \$100.00 of my deductible expenses. For the next \$8,000.00 of claims, I will need to pay my coinsurance at 10% rate and my employer will fund the difference between the amount owed to the provider and my portion of the co-insurance. For the next \$3,600.00 of claims, I will be responsible for my co-insurance at a rate of 25%. (My maximum out-of-pocket expense will not exceed \$1,800.00)

I have family coverage under the group health plan with a \$1,800.00 deductible and \$7,200.00 out-of-pocket maximum

I understand that I cannot submit claims to this account until I have paid the first \$100.00 of my deductible on one family member or \$200.00 for my family in total. For the next \$8,000 of claims for one person or \$16,000.00 for my family, I will need to pay my coinsurance at a 10% rate and my employer will fund the difference between the amount owed to the provider and my portion of the co-insurance. For the next \$3,600.00 worth of claims for one family member or \$7,200.00 for my family, I will be responsible for my co-insurance at a rate of 25%. (My maximum out-of-pocket expense will not exceed \$3,600.00.)

Date Expense Incurred (mm/dd/yy)	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Amount Incurred
<input type="checkbox"/> Attach a statement of benefits from your insurance provider that shows the deductible/co-insurance expenses claimed.				
			Total HRA Deductible/Co-insurance Expense Claim*	\$

I will attach an explanation of benefits showing the amount of the deductible fulfilled with my HRA Deductible Expense Claim. I will attach an explanation of benefits showing the amount of co-insurance fulfilled with my Co-Insurance Claim. I will only request payment of funds not previously requested.

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Health Reimbursement Arrangement Plan with respect to such expenses and that the medical expenses have not been reimbursed 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 this 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 city income tax on amounts paid from the Plan which relate to such expense.

Employee Signature

Date
