Health Reimbursement Arrangement
Reimbursement Request Form

PLEASE PRINT

_____ XXX-XX-_____
Last Name First Name M.I. Social Security Nbr (Last 4 Digits Only)

Address:_____
Street City State Zip

_(_____)_____ _____ _____(____)_____
Home Phone Employer Name Work Phone

☐ Check box if this is a new address.

A copy of the Explanation of Benefits (EOB) OR a letter received from your health insurance plan MUST accompany this completed form in order to process your HRA reimbursement request and show proof of deductible met.

Date of Expense or EOB	Name of Covered Participant	Relationship to Employee (Self, Spouse, Child)	Type of Expense	Total Expense
				$
				$
				$
				$
				$

Reimbursement Total $_____

By my signature below I certify that I and/or my spouse and/or dependent child incurred expenses detailed above and are eligible for reimbursement under the above employer's Health Reimbursement Arrangement. I have attached a true and accurate Explanation of Benefits or other acceptable documentation. I also certify that expenses detailed above have not been and will not be reimbursed by any health insurance or reimbursement plan. I am not applying these expenses toward any federal or state income tax deduction or credit. I assume all responsibility for any taxes or penalties arising out of any disallowed deductions.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

_____ _____
Your Signature Date

Keystone Flex Administrators, L.L.C.
P.O. Box 5502 Edmond, OK 73083
#405-285-1144/Toll Free #866-680-8308 FAX #405-285-1763/Toll Free #855-259-1779