

Section 105 Health Reimbursement Arrangement (HRA) Claim Form

Employee Name (please print):

Mail or fax this form to:

Diversified Benefit Services, Inc.

P.O. Box 260

Hartland, WI 53209 Fax: (262) 367-5938

For additional claim forms log on at www.dbsbenefits.com

Indicate here if your address/information has changed:

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	Date://	.
Who incurred the expense? (check all that apply) To expedite you Section 105 expense reimbursement clai area. You must attach proper document explanation of Benefits (Expense is sent to you by your interest to the expense is sent to you by your interest to the expense is sent to you by your interest to the expense is sent to you by your interest to the expense is sent to you by your interest to the expense is sent to you by your interest to you be your interest to you be your interest.	UCTION GUIDE IN F ☐ Employee ☐ Spouse ☐ Dependent reimbursement ple m form and remembursement form and remembursement form and remembursement form and remembursement form you insurance after it has	ase complete the top portion of the per to sign your name in the appropriate orm for reimbursement. An example is ar medical insurance provider. This as been processed.
	SECTION 105 HE/SEE INSTRI Who incurred the expense? (check all that apply) To expedite you Section 105 expense reimbursement clai area. You must attach proper document an Explanation of Benefits (Ereport is sent to you by your	SECTION 105 HEALTH REIMBURSEN SEE INSTRUCTION GUIDE IN F Who incurred the expense?

By signing this form, I certify that the amounts listed are correct and are expenses that represent qualified reimbursable expenses. I will not claim these items on my personal income tax return for medical itemization nor claim any dependent care reimbursement expenses as tax credit. I certify that I will not be reimbursed for the expenses listed below from any insurance company or insurance plan or the following: any other Flexible Benefit Plan, Medical Savings Account (MSA), Health Reimbursement Arrangement (HRA), Health Savings Account (HSA), another reimbursement plan or any other source. I also certify that the expenses have been incurred and dates of service are during the timeframe required by the benefit plan. I will also provide documentation necessary to support the amounts being requested for reimbursement. In addition, by signing this document, I acknowledge and agree that DBS may, in the case of an overpayment (fraudulent, inadvertent or otherwise), offset future expense reimbursements to me to account for such an overpayment. I also agree to immediately inform DBS if I become aware of an overpayment and agree to reimburse the Plan Sponsor to the extent that an offset of future reimbursements is either impossible or inconvenient. Finally, I certify that I am aware that I may be reimbursed from the Plan only for my own expenses, expenses of my spouse, and expenses of my "dependent" children as defined by my employer's Plan.

Customer Service: 800-234-1229 • Fax: 262-367-5938 • www.dbsbenefits.com