luminare health℠

# HRA Account

HEALTH REIMBURSEMENT
ACCOUNT REIMBURSEMENT
REQUEST FORM

**Phone: 1-877-267-3359** **Fax: 1-866-514-8287**

## A. EMPLOYEE INFORMATION

| Name | Social Security Number (last 4 digits) | Name of Employer |
|---|---|---|
| Member ID | Phone Number | Email Address |

## B. HEALTH REIMBURSMENT ACCOUNT

| Date(s) of Service | Name of Service Provider | Patient Name | Type of Expense (Office Visit, Dental, Eyeglass, RX, Co-Pay, etc.) | Amount Requested |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | **TOTAL AMOUNT REQUESTED** | $ |
| | | | | |

## C. CERTIFICATION

I certify that the following is true:

- I wil1 use my HRA to pay for IRS-qualified expenses, permitted under my Employer's HRA plans(s) provided to me and my IRS-eligible dependents, on the date(s) indicated above as being incurred within my period coverage
- I have not and will not seek reimbursement for the medical expenses claimed on this HRA form through any other source. Prohibited sources include, but are not limited to, individual and group health insurance, HMO's, self-insured plans, etc.
- I will not claim any reimbursed HRA expenses for federal income tax deductions or credit, and will request reimbursement only after the services have been provided
- I will collect and maintain sufficient documentation to substantiate my reimbursed HRA expenses to respond to any IRS or Employer inquiries I may receive.
- The eligibility of medical expenses under an HRA Plan is subject to IRS and FDA regulatory change at any time.
- I specifically release my Employer and Luminare health from any liability resulting from either my participation in any HRA or for any misrepresentation I make regarding my HRA requests for reimbursement.
- Where improper reimbursement of ineligible HRA expenses has been made, the corrective procedure approved by the IRS and permitted under my Employers HRA plan will be followed
- I have read and understand the information on the front of this form.

| Employee Signature | Date |
|---|---|
| | |

**Submit claim(s) electronically at myLuminareHealth.com or through our convenient mobile app at myTrustmarkBenefits Accounts**

Or return this form to:
Benefits Spending Accounts
P. O. Box 2968
Clinton, IA 52733
Phone: 877-267-3359
Fax: 866-514-8287
Email address:FlexHB@LuminareHealth.com