AssuredPartners
BENEFIT ADVISORS

This Claim form serves as the cover page.	Complete when faxing:_____ # of Pages. Daytime phone #:

Health Reimbursement Account Form

Group: ALLEGHENY EAST CONFERENCE	Date of Claim: 03/01/2020
Name of Employee: First MI Last JOHN L. DOE	Social Security #: 123-45-6789
Address: Street City State Zip Code 123 PENN STATION, PA 19455	Daytime Phone #: 476-123-4567

Expense Information (please print)

Complete the following information for each claim expense item. Attach supporting EOB documentation for each expense. The claim form and documentation must list the dates that the service was performed, provider name, type of service, patient name, and your portion of the charge for the service.

Date of Service	Patient Name	Relationship to Participant	Name of Provider	Description of Service	Reimbursement Requested
SEE	ATTACHED	EOB			
				Total Requested Reimbursement Amount	$

This is to certify that my statements on this Claim Form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for my eligible dependents. I certify that these expenses have not been, nor will be reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction.

Signature: X _____ Date: 3/2/2020

You must complete all sections above. Failure to complete all sections of this form or to attach supporting EOB documentation will delay your reimbursement.

Send Deductible Reimbursement Arrangement Claim Form and supporting EOB documentation to AP Benefit Advisors, LLC:

EMAIL: fsa@apbenefitadvisors.com
FAX: 410-771-9487
ADDRESS: AP Benefit Advisors, LLC
Attn: Claims Department
200 International Circle, Suite 4500
Hunt Valley, MD 21031
Customer Service 1-800-657-6265 | Hours: 8:00 a.m. - 5:00 p.m.