A Turn For The Better

HRA (Section 105) Reimbursement Form

Employee Name: ____

Employee Address: ____

Patient Name and Date of Birth: ______________________

Employer/Company Name: **Town of Newtown and BOE**

Complete the table below and attach a copy of the applicable Explanation of Benefits.

Date of Service	Patient Name	Provider / Facility Name	Expense Submitted

Total Expense Submitted $______________

I certify that to the best of my knowledge that the above listed expenses are not being reimbursed by any other medical plan and are eligible under the Section 105 Plan sponsored by the Employer.

Signature _______________________________ Date ___________

Send this form and required documents to the address listed below, fax it to (203) 877-9558, or email it to hrabps-stirling@90degreebenefits.com.