Jefferson County Commission
2019/2020 PLAN YEAR HRA REIMBURSEMENT CLAIM FORM

Millenium Insurance Group, 135 East Main St., New Holland, PA 17557

Toll Free Telephone: (888) 577-7373 / Email Claims to: smartin@millig.com / Fax Claims to: (717) 354-0459

Employer Name:	**Jefferson County Commission**	
Employee Name:		SSN: (last 4 digits only)
Address: (complete only if address changed)		

HRA Reimbursement Account - Reimbursement Request

All Reimbursement Requests will be adjudicated based on the employers plan specifications.

Claimant Name & Relationship Employee / Spouse / Dependent	Date of Service	Type of Service	Dollar Amount
☐ Check this Box if EOB Copies are being Submitted via Email **(if emailed no need to complete this section to list each claim by member)**			
			$
			$
			$
			$
		Total:	$
**(REQUIRED) Do you and/or your Enrolled Dependent(s) have any Medical Benefits Insurance Coverage (Primary or Secondary) other than the Jefferson County Commission Group Medical/Rx Plan & the HRA Benefit? ☐ YES ☐ No			

To the best of my knowledge and belief, my statements in the requested expenses are complete and true. I am requesting reimbursements only for eligible expenses incurred during the applicable plan year for myself and my eligible dependents. **I certify that these expenses have not been and will not be reimbursed under another employer sponsored benefit plan** and will not be claimed as an income tax deduction. In addition, **I certify that these expenses have not been previously reimbursed under this plan or under any other HRA Plan**. I authorize that my plan account may be reduced by the amount of the requested reimbursement.

_____   _____/_____/_____

Employee Confirmation Signature   Date

A COPY OF THE APPLICABLE EOB (EXPLANATION OF BENEFITS) MUST BE ATTACHED OR REIMBURSEMENT WILL NOT BE PAID.

Do not write in the box below.

Date Received by Administrator _____/_____/_____

Notes: