

# Jefferson County Commission

## 2023/2024 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](mailto:smartin@millig.com) / Fax Claims to: (717) 354-0459

|   |                           |
|---|---------------------------|
| Employer Name: <b>Jefferson County Commission</b>             |                           |
| Employee Name:  | SSN: (last 4 digits only) |
| Address: ( <a href="#">complete only if address changed</a> ) |                           |

### HRA Reimbursement Account - Reimbursement Request

All Reimbursement Requests will be adjudicated based on the employer's plan specifications.

| Claimant Name & Relationship<br>Employee / Spouse / Dependent  | Date of Service | Type of Service | Dollar Amount |
|--|-----------------|-----------------|---------------|
| <small>(Not required to list each claim in this section. Your submission should contain the Year-to-Date Patient or Program Deductible Benefit Summary Page along with each detailed EOB processing page)</small>  |                 |                 |               |
|  |                 |                 | \$            |
|  |                 |                 | \$            |
|  |                 |                 | \$            |
|  |                 |                 | \$            |
| <b>Total:</b>  |                 |                 | \$            |
| <b>** (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 &amp; the HRA Benefit? <input type="checkbox"/> YES** <input type="checkbox"/> No</b> |                 |                 |               |
| <b>** If you checked the Yes box, then you will need to Complete &amp; Submit the COB (Coordination of Benefits) Form</b>  |                 |                 |               |

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 of Signature

**A COPY OF EACH APPLICABLE DETAILED PROCESSING EOB (EXPLANATION OF BENEFITS) MUST BE ATTACHED OR REIMBURSEMENT WILL NOT BE PAID.**

|   |
|---|
| Date Received by Administrator ____/____/_____<br>Processing Notes: |
|---|