Jefferson County Commission

2024/2025 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 employer's plan specifications.

Claimant Name & Relationship Employee / Spouse / Dependent	Date of Service	Type of Service	Dollar Amount
(Not required to list each claim in this section. Your submission should contain the Year-to-Date Patient or Program Deductible Benefit Summary Page(s) along with each detailed EOB processing page)			
			$
			$
			$
			$
		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**

****If you checked the Yes box, then you will need to Complete & Submit the COB (Coordination of Benefits) Form**

To the best of my knowledge and belief, my submission regarding 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 _____/_____/_____

Processing Notes: