

Jefferson County Commission

2025/2026 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
<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(s) along with each detailed EOB processing page)</small>			
			\$
			\$
			\$
			\$
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? <input type="checkbox"/> YES** <input type="checkbox"/> No			
** If the Yes box is applicable, 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 is 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 this 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:
