VOUCHER FOR HRA EXPENSES

Claim for Reimbursement

Fax No: 270-769-2521 or 1-866-812-9671

Mail to Address: Employee Benefits Administrators
P.O. Box 2525
Elizabethtown, KY 42702

NAME____

ADDRESS____CITY_____________________STATE________ZIP______

SOCIAL SECURITY____________________EMPLOYER____

HRA EXPENSE CLAIMS

Name of Person Expense Covers	Date of Service when expense occurred	1.Service Provider Name 2.Description of Expense	Net Claim Amount
____________________	__________	1.______________________________	
		2.______________________________	________
____________________	__________	1.______________________________	
		2.______________________________	________
____________________	__________	1.______________________________	
		2.______________________________	________
____________________	__________	1.______________________________	
		2.______________________________	________
____________________	__________	1.______________________________	
		2.______________________________	________
____________________	__________	1.______________________________	
		2.______________________________	________
____________________	__________	1.______________________________	
		2.______________________________	________

TOTAL MEDICAL CARE EXPENSE CLAIM $_______

Read Carefully

The above is a true and accurate statement of unreimbursed medical expenses incurred by me or my eligible dependents on the date(s) indicated, and was incurred while I was covered under the Company's ProPlus 125 Cafeteria Plan. I have submitted any medical expenses covered by other medical plan(s) to those plans, but payment has been denied in full or in part, as shown on the attached form. Receipts from my service provider(s) for all expenses are attached to this voucher. I understand I can not claim any reimbursed expenses on my income tax return, and that I may be liable for payment of all related taxes including Federal, State, or City income tax on the amounts paid for any expense improperly claimed under the plan.

Signature____ **Date**_____/_____/_____