Return the completed Claim Form and documentation to:
Toni Ann Amature, Benefits Administrator
Independent Pension Services, Inc.
114 Old Country Rd., Ste. 520, Mineola, NY 11501
Phone: 516-747-5210 Fax: 516-385-2124
Secure Email: https://independentpension.securefilex.com

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) CLAIM FORM

I. Participant Identification (Please print or type)

Company/Location: ______________________________

Participant Name: ______________________________

Mailing Address: ______________________________

____

Social Security Number: ________ - ______ - ________ Email: ______________________

II. Attach Receipts/Invoices (Please use a separate sheet if more space is needed)

Date of Service	Physician or other Provider	Amount	Patient's Name	Self	Spouse	Dependent
________	______________________	$______	____________	☐	☐	☐
________	______________________	$______	____________	☐	☐	☐
________	______________________	$______	____________	☐	☐	☐
________	______________________	$______	____________	☐	☐	☐
________	______________________	$______	____________	☐	☐	☐
________	______________________	$______	____________	☐	☐	☐
________	______________________	$______	____________	☐	☐	☐
________	______________________	$______	____________	☐	☐	☐
________	______________________	$______	____________	☐	☐	☐

III. Total Amount Requested $______.____

IV. Statement by Participant

To the best of my knowledge and believe my statements in this Form are complete and true. I certify that: either I or a family member has received the services described above on the dates indicated, the expenses are out-of-pocket expenses that qualify as valid Medical Care Expenses under the Plan, and that these expenses have not been reimbursed or are not reimbursable under the major medical plan or any other health plan such as my Spouse's Plan.

______________________________ ______________________
Participant Signature Date

For administrative use only

Reviewed by: __IPS/TONI ANN___ Date: ____________ Plan Year: ____________ Benefit: __HRA___
Approved: $_______.___ Denied: $_______.___
Reason For Denial: ______________________ Action To Be Taken: ______________________