Please fax completed form to: (973) 529-0372

Health Reimbursement Arrangement
Reimbursement Claim Form

Toll Free: (877) 505-9500
Fax: (973) 529-0372
www.cdhplans.com

Employer:________________________________

Employee Name:__________________________ Social Security Number:__________________________

Phone:________________________________ E-mail:______________________________________

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Healthcare Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
➨ *Attach appropriate receipt(s) and submit with this claim form.*			**Total Medical Care Expense Claim**	**$**

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Health Reimbursement Arrangement with respect to such expenses and that the medical expenses have not and will not be reimbursed under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Your Health Reimbursement Arrangement (HRA) Plan may be limited to the types of healthcare expenses that may be reimbursed to you. Please read the Summary Plan Description for your HRA Plan, for a list of eligible expenses.

______________________________________ ______________________
Employee's Signature Date