WIMBERLY ASSOCIATES, INC.

Health Reimbursement Arrangement (HRA)

Claim Form

150 Cunningham Pond Rd. | Peterborough, NH 03458
Phone: 877-884-6582 | Fax: 888-653-6034
Balances: 913-789-4600 | Email: claims@wimberlyassociates.com

Employer: _____

Employee: _____

SSN: XXX-XX-_____

Date Incurred	Service Provider	Expense Description	Person For whom Expense Incurred	Net Amt
Total Amount of Claim				*$*

The undersigned participant in the Plan certifies that all expenses for which reimbursement is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Section HRA Plan with respect to such expenses and that the medical expenses have not been reimbursed under other health plan coverage.

Employee's Signature: _ Date: _

CLAIM FILING INSTRUCTIONS

This claim form must be accompanied by an Explanation of Benefits from your group health insurance provider.