Herscher Community Unit School District No. 2

DR. RICHARD S. DECMAN, SUPERINTENDENT
SHELLY PARSONS, SPECIAL SERVICES DIRECTOR
DR. PETE FALK, CURRICULUM DIRECTOR

Health Reimbursement Request Claim Sheet (HRA)

Employee Printed Name: ______________________________

Home Address: ____

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Email Address: ________________________________ Phone Number: ____________________

This form must be completely filled out and the necessary documentation* must be attached to be eligible for reimbursement.

*Necessary documentation is the Explanation of Benefits (EOB) that states that you have exceeded your portion of the deductible. Bottom of EOB will state: "***Benefit Period: 01-01-(year) through 12-31-(year) To date this patient has met $xx of her/his $2,500 Health Care Plan Deductible.***" We cannot accept an EOB which only mentions Out of Pocket amounts.

Reimbursements are available to those employees enrolled in the HRA-PPO AND have exceeded the $500 or $750 deductible, depending on completion of annual biometric screening.

Reimbursements are done as part of the bills approved at the Board of Education meetings.

If you have any questions, please contact Heather Crane, Payroll/Human Resources at 815-421-5016 or via email at craneh@hcusd2.org.

Date of Expense: __________________________

Name of individual whom expense was incurred: ________________________________

Relationship to employee: __________________________________

Employee Signature: ____________________________ Date Submitted: ________________

☐ EOB stating deductible attached

Reimbursements MUST be received 90 days after the plan year end (March 31) to be eligible for reimbursement. Keep a copy for your records.

DISTRICT OFFICE USE ONLY

Received ___/___/______

Bio ☐

Processed for _____________ BOE mtg

"Education…The Ultimate Investment."