HERSCHER CUSD #2

Health Reimbursement Request Claim Sheet

Employee NAME: _____ Date: _____

Mailing Address: _____

_____

Email Address: _____

Daytime Phone: _____ Evening / Cell Phone: _____

This form must be completely filled out and the necessary documentation attached to receive your reimbursement!

*Please note that all reimbursement requests must be received 90 days after the plan year end to be eligible for reimbursement.

Necessary documentation includes the explanation of benefits (EOB) indicating that you have exceeded your portion of the deductible (*only applicable to those employees enrolled in the HRA PPO and that have exceeded the $500 or $750 deductible, dependent on completion of screening*). If you have any questions about acceptable documentation please contact Crissy Livingston, Herscher Unit Office at 815.421.5016.

Date of Expense: _____

Name of person whom the expense was incurred: _____

Relationship of that person to employee (self, spouse, child): _____

Signature:_____

REMIT THIS FORM ALONG WITH THE NECESSARY DOCUMENTATION TO CRISSY LIVINGSTON VIA EMAIL TO LIVINGSTONC@HCUSD2.ORG OR VIA FAX AT 815-426-2872.