Ursinus College
Health Reimbursement Arrangement
Claim Form

Name	
Home Address, City, State, Zip Code	
Social Security # (Last 4 Digits)	**Daytime Phone Number or email**

Date of Explanation of Benefits Form	Amount

Date of Prescription Drug Purchase	Amount

Please attach your Explanation of Benefits Form and/or Receipts to this Claim Form

I certify that the expenses being submitted were incurred while covered under the Company's Health Reimbursement Arrangement, and have not been reimbursed by any other source. If the claim is not valid, I recognize that I will be liable for payment of all taxes on amounts paid from the Plan which relate to that expense. I recognize that I cannot claim these expenses on my personal income tax return.

Employee Signature	Date

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