Health Reimbursement Arrangement Claim Form

Employer Name: _____ Employer Group#: _____

Employee Name: _____ SS#: _____

Home Address: _____ E-Mail Address: _____

City: _____ State: _____ Zip: _____ Telephone #: _____

In order to submit a claim, you must submit a copy of the EOB from your group medical plan for qualified service

Date of Service	Provider Name	Description	Amount
			$
			$
			$
			$
			$
			$
			$
		Total Reimbursement Request:	**$**

The undersigned Employee certifies that all expenses hereby submitted are for services incurred during the current Plan Year by the Employee, his/her spouse, or qualified dependent. Furthermore, by signing, the Participant also certifies that these expenses are not reimbursable, in whole or in part, under any other plan of insurance or other benefit. The Employee understands that he/she is responsible for the accuracy and veracity of expenses submitted and that he/she may be responsible for any tax consequences and/or penalties arising from improper submission and reimbursement of the above expenses under the Participant's Section 105 Medical Reimbursement Plan. I understand there is a five (5) business day cut-off for submission of claims prior to each check run date.

Signature: _____ Date: _____

Mail to: Paragon Benefits, Inc.
CDHC Department
P. O. Box 12288
Columbus, GA 31917

Email to: hrasupport@paragonbenefits.com
Toll-Free Customer Service: (866) 661-5078
FAX to: (706) 256-4023

REMEMBER: IN ORDER TO PROCESS YOUR HRA CLAIM, AN EXPLANATION OF BENEFITS FROM YOUR GROUP MEDICAL CARRIER MUST ACCOMPANY A COMPLETED AND SIGNED CLAIM FORM