

Please attach the required documentation to this form and mail, fax or email to:

Stanley, Hunt, DuPree & Rhine
Post Office Box 6400
Greenville, SC 29606

Fax: 1-252-293-9048 or 1-252-293-9049 Number of pages in this fax _____
Email: shdrflexclaims@shdr.com

OPTIONS FOR OBTAINING ACCOUNT INFORMATION:
1-800-930-2441 or 1-800-768-4873 (Monday thru Friday 8:00 a.m.-6:00 p.m. ET)
website www.shdr.com/flex

Your Employer _____

Health Reimbursement Account (HRA) Claim Form

Employee Name: _____ Social Security Number: _____

Daytime Phone Number: _____ Email: _____

Based on your employer's plan specifics, supporting documentation will be either an itemized statement listing the below items or an Explanation of Benefits (EOB) showing the portion paid by insurance.

Provider Name	Person for whom Expense was incurred	Relationship	Date of Service	Description of Service	Amount Requested
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
					\$
Total Reimbursement Requested					\$

Employee Certification

1. The health care expenses claimed above are not eligible for reimbursement by any insurance carrier or other employer-sponsored plan.
2. The expenses claimed above have not been and will not be taken as a credit or deduction on my personal income tax return.

Employee Signature _____ Date _____

Claims cannot be processed without the participant's signature and required supporting documentation