Please attach the required documentation to this form and send to:
Stanley, Hunt, DuPree & Rhine, Inc.
Post Office Box 6400
Greenville, SC 29606 OR
Fax number 1-252-293-9048 or 1-252-293-9049
OPTIONS FOR OBTAINING ACCOUNT INFORMATION:
website www.shdr.com (pin# required) Interactive Voice Response 1-800-413-6706
1-800-930-2441 or 1-800-768-4873 1-864-527-0785 (Monday thru Friday 8:00 a.m.–6:00 p.m. EST)

Employer _____

Medical Reimbursement HRA Claim Form

Employee Name: **Social Security Number:**

Daytime Phone Number: **E-Mail:**

UNREIMBURSED MEDICAL EXPENSES (Attach supporting documents)

Does your receipt include all of the following?

- Provider's name
- Service provided
- Actual date(s) of service**:**
- Provider's address
- Amount billed

Date of payment is not sufficient

Person for Whom Expense was Incurred	Date(s) of Service	Name of Service Provider	Description of Services		$ Amount
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
			Total Reimbursement Requested		**$**

Employee Certification

1. The health care expenses claimed above are not eligible for reimbursement by any insurance carrier or 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.

_____ _____

Participant Signature **Date**

Claims cannot be processed without the participant's signature.

SHDR
STANLEY, HUNT, DUPREE & RHINE, INC.
Benefit Consultants
A subsidiary of BB&T

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