Submit completed claim to:
The Loomis Company
Flexible Benefits Administration
P.O. Box 7011
Wyomissing, PA 19610
Or Fax to 610-378-7913
Email: flexclaims@loomisco.com

HEALTHCARE REIMBURSEMENT ARRANGEMENT (HRA)
Reimbursement Claim Form

TO EXPEDITE CLAIM PAYMENT, PLEASE COMPLETE SECTIONS I, II, III, SIGN YOUR CLAIM FORM AND ATTACH REQUIRED DOCUMENTATION.

PART I: EMPLOYEE INFORMATION**:** **GROUP#**

Employee Name (Last/First/MI):	**Member ID (located on your ID card):**

PART II: REIMBURSEMENT REQUEST

Patient Name	Date(s) of Service From:	To:	Provider of Service	Total Charges	Amount Health Care Plan Paid	Reimbursement Requested
				Total Reimbursement Requested		**$**

PART III: EMPLOYEE CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for which I am requesting reimbursement meet all of the conditions listed below.

- The above information is correct.
- Were incurred for services and/or supplies received by my eligible dependents or me under the plan.
- Were for services or supplies furnished on or after the effective date of my Account for additional health care.
- I have not been reimbursed for these expenses in any other way nor shall I seek any other reimbursement and I will advise The Loomis Company of any adjustments to the health care plan claims payments which may alter or impact this request for reimbursement.

I understand that reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I further certify that I have not deducted nor will deduct on my individual income tax return any of the expenses reimbursed through my Healthcare Reimbursement Arrangement. I understand that reimbursement will be made in accordance with the provisions of the plan in which I participate. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting and liability.

_____ _____

Employee Signature Date