

JRM Benefit Administrators, LLC

Attn: Claims Department
 PO Box 277
 Onalaska, WI 54650
 Phone: (608) 781-8712
 Claims Fax: (608) 781-8713

MEDICAL EXPENSE REIMBURSEMENT PLAN (MERP) REIMBURSEMENT CLAIM FORM

➔ Reminder: *Read the instructions on the reverse side of the claim form before completing.
 To expedite your claim, please provide ALL appropriate information showing the date and description of service.*

Social Security Number	Daytime Phone Number
Last Name	First Name
Employer Name	
Email Address	
<input type="checkbox"/> Change of Address:	

<p>Are You a FSA Plan Participant?</p> <p><input checked="" type="checkbox"/> Check the Box that Applies to You</p> <p><input type="checkbox"/> Use available FSA Plan balance for reimbursements on medical expenses not covered by the HRA Plan. If you have additional FSA claims you must use a FSA Form.</p> <p><input type="checkbox"/> Only use HRA Plan for Reimbursement</p>

Unreimbursed Medical Expense Claims Do not lump line items together, services must be itemized.

Date of Expense	Name of Service Provider	Service Provided		Name of Covered Dependand	Relationship to Employee	Net Amount	Office Use Only
		Deductible	Co-insurance				
		<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>				

✓ **Attach the appropriate EOB(s) and submit with this claim form.**

Total HRA Claim:

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NOTE: Your Health Reimbursement Arrangement (HRA) may be limited by the types of healthcare expenses that may be reimbursed to you. Please read the Summary Plan Description for your HRA for a list of eligible expenses.

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Health Reimbursement Arrangement (HRA) with respect to such expenses and that the medical expenses have not and will not be reimbursed under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Employee Signature is required to process this claim. Spouse or dependand cannot sign claim form.

Employee's Signature _____

Date _____

<p>Office Use Only</p> <p>Date Received _____</p> <p>Notes _____</p>

Instructions and Helpful Hints

General Information

- Submit your completed claim form and attached documentation to: JRM Benefit Administrators, LLC, Attn: Claims Dept, PO Box 277, Onalaska, WI 54650 or fax to (608) 781-8713. When faxing please do not follow-up with a hard copy in the mail.
- If you have not received any correspondence (reimbursement check, direct deposit, letter, and/or email) or a telephone call from us after ten (10) days from submitting your claim please contact our office with questions at (608) 781-8712.

Employee Profile

- Please fill in *ALL* the requested information. Remember to print your information so we can process your claim accurately.

Website

- To access the Web site go to: www.repayme.com/admin/default.asp?cn=JJA or www.jrmcpa.biz and select "links" on the left side of the screen and then select "JRM Benefit Administrators - participant login" from the list.
- For first time users follow these steps: At the login screen enter: "Login ID" (your social security number), "PIN" (last 4 digits of social security number), "Login Method Using" (select social security number). Note: with your first login, you will be prompted to change your PIN. After completing the questions and selecting "change PIN" you will be able to view your account and submit claims.
- When you are done viewing your account select "Logout".

Unreimbursed Medical Expense Claims

- Please fill in *ALL* of the fields. This information is required and must be filled in for your claim to be processed.
- Provide a copy of the Explanation of Benefits (EOB) from your insurance company. The EOB is required to process your claims per the Plan Document rules.
- If faxing your claim, *do not highlight the medical expense* because the item is blacked out on the receiving fax.
- Please list each expense individually on the claim form, do not lump items together. Listing out each expense speeds up the claim processing procedure and you will receive your reimbursement sooner.
- Only submit copies of the Explanation of Benefits (EOB). You should keep all originals for your personal records.

Employee Signature

- Be sure to sign and date this claim form before submitting it for reimbursement. We cannot process your claim with this part missing.
- The **employee** can only sign this claim form; spouse or dependant **CANNOT** sign this form.

JRM Benefit Administrators

Your online account has everything you

Need to manage your HRA Plan