Health Reimbursement Plan (HRA)

St. Clairsville Schools

REQUEST FOR REIMBURSEMENT

Please provide necessary information on this form and attach the appropriate Explanation of Benefits (EOB) from the insurance company. All reimbursements will be payable to the employee.

Employer		Group #		Date:
St. Clairsville Schools		**0217353**		
Employee's Last Name	First Name	MI		Social Security Number
Employee's Address	City	State	ZipCode	Phone # (9a.m. – 5p.m.)

Amount to be considered for reimbursement: $_____*

Amount approved: $_____

(*) EOB must be attached.

Did you receive a discount from a provider on any of the EOBs you are submitting for reimbursement? Yes___ No____ (If yes, you must supply a copy of the bill showing the discounted amount paid)

Do you or any of your covered dependents have secondary health insurance coverage that will pay following the Schwendeman Agency, Inc. policy? Yes___No____

To the best of my knowledge and belief, my statements in the Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plan.

Signature: _____ Date: _____

SCHWENDEMAN AGENCY INC.

Submit via Mail, Fax or Email:

Schwendeman Agency, Inc.
Attention: Christi Mullins
109 Putnam Street
Marietta, OH 45750

Phone: (800) 837-6793
Fax: (740) 373-7025
Email: c.mullins@schwendeman.com