80 Munson Street, LeRoy, NY 14482 585.344.7616

HEALTH REIMBURSEMENT ACCOUNT (Section 105)
REIMBURSEMENT FORM

Employer Name (District): _____
Participant's Name: _____
Address: _____
City: _____State: _____Zip:_____
Phone: _____E-Mail Address _____

The undersigned participant in the plan requests reimbursement in the amounts shown below:

NOTE: Federal law requires that you submit a written statement (such as an itemized bill from the benefit provider) as well as proof that the claim is not being reimbursed by Insurance Company (Explanation of Benefit). Also, you will not be entitled to claim this expense as a tax deduction.

Date Incurred	Name of Service Provider	Describe Expense	Person for Whom Expense Incurred	Amount

Total this page: _____

Total from back: _____

Total amount of medical expense/claims: _____

READ CAREFULLY
The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the participant was covered under the Plan with respect to such expenses. The participant 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 participant, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the participant may be liable for payment of all related taxes on amounts paid from the Plan which relate to such expense. The participant further understands that no medical expense tax deduction or credit is permitted for amounts for which reimbursement is made.

_____ _____
Employee Signature Date

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Date Incurred	Name of Service Provider	Describe Expense	Person for Whom Expense Incurred	Amount

Total: _____

(Enter here and on front of form)

Send completed claim forms to:

Genesee Valley BOCES
HRA Program
80 Munson Street
LeRoy, NY 14482

Genesee Valley Educational Partnership
success stories written here