EDEN II SCHOOL FOR AUTISTIC CHILDREN, INC.
HEALTH REIMBURSEMENT ACCOUNT CLAIM FORM

Send Forms to: **HUB International NE**
1393 Veterans Memorial Highway- Suite 210N
Hauppauge, NY 11788
Attn: Joanne Miller or Phyllis Cox

Name: ______________________________________ **Address Change?** ____**YES** ____**NO**

Address:__________________________**Apt#**_____ **Telephone #** (_____)_______-__________

______________________________________ **Social Security #**______/_______/_______

Unreimbursed Medical Expense Claims

Date Expense Incurred	**Name of Service Provider**	**Expense Description**	**Person For Whom Expense Was Incurred**	**Net Amount**
ATTACH REQUIRED DOCUMENTATION			**Total Medical Care Expense Claim Amount**	

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 undersigned was covered under the Company's HRA Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable 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 the 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's Signature Date

Contact for claims questions:
Joanne Miller - (631) 360-5308 or Phyllis Cox (631) 360-5309
Fax # (917) 934-5315 or (917) 934-5316

HRA