J. J. STANIS and COMPANY, INC.

377 Oak Street Suite 406 * Garden City, NY 11530
(516) 465 3900 Fax: (516) 465 3920

HRA Claim Form

Employee:_____

Employer Name: _____

Social Security Number: _____

This form should be copied for future use.

Fill out for change of address only
New
Address: _____

City: __ _____

State, Zip: _____

Phone: _____

Please attach the EOB (Explanation of Benefit) in the order you have listed below and fill in with dates of service, description, and claim totals. Please sign and date the form and mail or fax to J. J. Stanis and Company, Inc. The EOB must include the following information: Date of Service(s), Type of expense (i.e. eye exam, lab test) Amount applied to the deductible and the Name of the Service Provider.

PLEASE NOTE: Cancelled checks or credit card receipts/statements are not valid forms of documentation.

Date(s) of Service	Description of Services	Dollar Amount
		$
		$
		$
		$
		$
		$
		$
	Claim Total	$

Reminders:

Provide an EOB for all expenses submitted.

Sign and Date the Reimbursement Form, J. J. Stanis cannot process an unsigned form.

Multiple expenses may be included on one form. If more space is needed, attach additional forms.

Minimum check is $10.00

Keep copies of everything submitted to J. J. Stanis and Company, Inc.

Mail completed forms to:
J. J. Stanis and Company, Inc, 377 Oak Street Suite 406 * Garden City, NY 11530

To access additional claim forms, please visit our website at:
www.jjstanisco.com

This is to certify that my statements on this Claim Form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for my eligible dependents. I certify that these expenses have not been, nor will be reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my HRA to be reduced by the amount requested.

Signature: ***X***_____ Date: _____