Town of Shelburne
Health Reimbursement Arrangement (HRA) Claim Form

If not using the on-line claims service

Name:	**Social Security #:**
Mailing Address	**City/State/Zip**
E-mail:	**Phone:**

IMPORTANT: this form is for reimbursement of health insurance deductible expenses, including prescription drugs. Employees must be covered under the Town of Shelburne Group Medical Plan. Employees are required to attach a detailed copy of the Explanation of Medical Benefits (EOB) statement from the health insurance plan or prescription drug receipt when requesting a reimbursement. Expenses may be incurred for you, your legally married spouse and/or dependents.

Health Insurance Deductible (maximum per calendar year): $4,000 (S) or $8,000 (2 person/family)

Prescriptions are considered an eligible deductible expense**;** therefore, 100% of an eligible prescription expense will be reimbursed by the HRA. Once the full Health Insurance Deductible has been met, the insurance will pay 100% of the eligible cost of prescription drugs.

Employee "co-pay" effective July 1, 2014: $20 per Explanation of Benefit (EOB) - Example: one EOB with 3 eligible deductible expenses totaling $100, employee would be reimbursed $80 ($20 paid by employee) or one EOB with one expense totaling $100, employee would be reimbursed $80 ($20 paid by employee).

Expenses must be incurred while you were an Employee during the Coverage Period July 1, 2014 – June 30, 2015

LIST TOTAL EXPENSES (space available on page 2)

Total Amount Claimed (from page 2)	$

The undersigned Employee in this Plan certifies that all expenses for which payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Plan and have not otherwise been reimbursed through insurance, the Town of Shelburne Cafeteria Plan or from any other source and will not be claimed as a federal income tax deduction. The undersigned further understands that he or she is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim.

Signature:	**Date:**

Mail completed form to:
Future Planning Associates, Inc.
ATTN: Shelburne Town Administrator
P.O. Box 905
Williston, VT 05495
Phone: (802) 857-0692; **FAX: (802) 857-0712; E-mail: jaime@futureplanningassoc.com**

This form must reach Future Planning Associates, Inc. by noon on Monday of any week
Disbursements are processed by the following Monday

Date Incurred	Person for Whom Expense is Incurred	Charge
Total		$

PLEASE REMEMBER TO ATTACH
PRESCRIPTION RECEIPTS AND/OR BCBS EOB's

EMPLOYEE AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT OF HEALTH CARE AND DEPENDENT CARE REIMBURSEMENTS

I hereby authorize and request that Future Planning Associates, Inc. (contracted by the Town of Shelburne to provide administration services for the Town of Shelburne Health Reimbursement Arrangement and Cafeteria Plan) to make payment of any Town of Shelburne Health Reimbursement Arrangement and Cafeteria Plan claims of any amounts to me by initiating credit entries to my account indicated below in the bank named below, hereinafter called BANK, and I authorize and request BANK to accept any credit entries initiated by Future Planning Associates, Inc. to such account and to credit the same to such account without responsibility for the correctness thereof.

I also authorize Future Planning Associates, Inc. to adjust any over deposits erroneously credited to my account if prior to the initiation of the correcting entry, Future Planning Associates, Inc. has sent or delivered to me written notice of the correction.

It is understood that this agreement may be terminated by me at any time by written notification to Future Planning Associates, Inc. Any such notification to Future Planning Associates, Inc. shall be effective only with respect to entries initiated by Future Planning Associates, Inc. after receipt of such notification and a reasonable opportunity to act on it. Any such notification to BANK shall be effective only with respect to entries credited to my account by BANK after receipt of such notification and a reasonable time to act on it.

I recognize, acknowledge and accept that this service is being provided for my convenience. As such, I agree not to hold the Town of Shelburne and/or Future Planning Associates, Inc. liable for errors made by them or the financial institution.

ATTACH A VOIDED CHECK OR DEPOSIT SLIP FOR SAVINGS ACCOUNTS

Name of Bank or Credit Union ***** _____

Account # _____ Routing # _____

***** Contact your Credit Union to verify your "Account" and "Routing" Numbers

Account Type: _____ Checking **(attach a voided check only, a deposit slip does not provide sufficient information)**
_____ Savings **(attach a deposit slip)**

Employee Name (Print)_____

Employee Signature: _____

Employee's E-mail: _____

NOTE: Any changes in Bank or Account Numbers must be made in writing and sent to:

Shelburne Town Plan Administrator
Future Planning Associates, Inc.
P.O. Box 905
Williston, VT 05495-0905

Phone: (802) 857-0692 **Fax:** (802) 857-0712 **E-mail**: jaime@futureplanningassoc.com

January 1, 2012

Town of Shelburne
Health Reimbursement Arrangement (HRA)
********All Eligible Employees must complete this form********
Personal Information/Enrollment Form

WE NEED THE FOLLOWING INFORMATION FOR ALL EMPLOYEES PARTICIPATING IN HEALTH REIMBURSEMENT ARRANGEMENT. **DUE TO PRIVACY ISSUES, WE WILL ONLY DISCUSS YOUR ACCOUNT WITH YOU UNLESS YOU HAVE RETURNED THIS COMPLETED FORM.**

YOUR NAME:	SOCIAL SECURITY NUMBER:
MAILING ADDRESS:	DATE OF BIRTH:
CITY, STATE, ZIP CODE:	PHONE:
E-MAIL :	**HICN #:

MARITAL STATUS:
(PLEASE CIRCLE) SINGLE MARRIED CIVIL UNION * SAME-SEX MARRIED* DOMESTIC PARTNER*

*** Due to Federal Income Tax Regulations, expenses for Civil Union, Same-Sex Married and Domestic Partners are <u>not</u> eligible for reimbursements under a Health Reimbursement Arrangement (HRA) unless the partner is considered a dependent and claimed as such on your federal income tax return.**

<u>List All Eligible Dependents</u>
If you need additional space, use the back of this form

FULL NAME ***(DO NOT INCLUDE YOURSELF)***	**** HICN NUMBER**	**SOCIAL SECURITY #**	**Date of Birth**	**M/F**	**Relationship To You**
JOHN/JANE DOE		00-00-0000	00/00/00	M/F	SPOUSE/PARTNER

******* If you or your dependents are receiving Medicare or Medicaid Benefits; please provide your/their HICN Number in the space(s) provided.*

If the status of your spouse or dependent changes during the plan year as your spouse or dependent, including a new spouse or dependent, you must contact the plan Administrator with these changes immediately.

Those named above, are ___, are not ___ (check one) authorized to discuss the status of my Health Reimbursement Arrangement, including payments of benefits, with Future Planning Associates, Inc.

SIGNATURE:	DATE:

PLEASE SIGN AND RETURN THIS FORM TO YOUR EMPLOYER

*****Did you remember to include the Medicare and Medicaid information?***
Yes ____ or Does Not Apply ____

Admin: Jaime Palmer, Ph: (802) 857-0692, jaime@futureplanningassoc.com, Fax: 857-0712