Group Benefit Services, Inc.
P.O. Box 4368
Lutherville, MD 21094
Toll Free: 800.337.4973
Fax: 410.321.8053
hraclaims@gbsio.net

GBS PREMIUM REIMBURSEMENT FORM

Employee Name:	Social Security #:
Home Address:	
Employer Name:	Phone #:

PLEASE READ CAREFULLY:

Please complete the above and attach a copy of your premium statement(s), invoice(s) or policy renewal letter from the insurance carrier showing your plan effective dates and premium costs. Please submit this GBS Premium Reimbursement Form to Group Benefit Services by using the mailing address, fax number or e-mail address shown above.

Upon receipt, Group Benefit Services will determine your eligible reimbursement benefit and return an Explanation of Benefit and reimbursement check to you.

If you have any questions, please feel free to contact our Customer Service Representative at the phone number listed above.

Employee Signature:_____ Date: _____

Elections under the HRA plan are binding for the entire Plan Year and cannot be revoked, modified or amended unless due to a limited family status change. Under penalty of perjury, you agree to use the debit card solely for the purchase of eligible medical expenses not covered by any other plan. You are responsible for providing proof to support reimbursed expenses and agree that any reimbursed expenses later discovered to be ineligible may be deducted from your paycheck by your employer. By electing the HRA plan, you authorize the release of claims information to your employer and Group Benefit Services, Inc., the Third Party Administrator for this plan.