Qualified Small Employer (HRA)
Reimbursement Claim Form

Employer: _____

Employee Name: _____ Soc. Sec. #: _____

Phone: _____ E-mail: _____

Monthly Insurance Premium claims:

Month of Premium (MM/YYYY)	*Name of Insurance Provider*	*Person for Whom Expense Incurred*	*Monthly Premium Amount*
For Medical, RX, Dental, Vision, OTC – Please provide Receipts. **For Insurance Premiums**	**Grand Total Insurance Premium(s)**		$

DIRECT DEPOSIT IS AVAILABLE (DOWNLOAD FORM FROM WWW.CPNFLEX.COM)

Read Carefully: *The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Health Reimbursement Arrangement (HRA) with respect to such expenses and that the insurance premium expenses have not and will not be reimbursed 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 this 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*

Mail/Fax/Scan Claim Form and Receipts to:
Corporate Planning Network, Inc. (CPN)
P. O. Box 1748 / Cordova, TN 38088
Phone: (800) 737-0125 / (901) 756-8244 / Fax: (901) 756-8322 / E-mail: claims@cpnflex.com