

20 Armory Lane ☐☐Milford, CT 06460-3347
Phone: (800) 447-6689 ☐☐Fax: (203) 876-1465
hrabps@stirlingbenefits.com

HRA (Section 105) Reimbursement Form

Employee Name: _____

Employee Address: _____

Patient Name and Date of Birth: _____

Employer/Company Name: _____

Complete the table below and attach a copy of the applicable Explanation of Benefits.

Date of Service	Patient Name	Provider / Facility Name	Expense Submitted

Total Expense Submitted \$ _____

Flex Account Authorization

I authorize the balance of the eligible attached claims not covered by my HRA plan to be paid to me from my Flex account.

Signature

I certify that to the best of my knowledge that the above listed expenses are not being reimbursed by any other medical plan and are eligible under the Section 105 and 125 Plans sponsored by the Employer.

Signature

Date

Send this form and required documents to:
Stirling Benefits, Inc., 20 Armory Lane, Milford, CT 06460-3347
Fax: (203) 877- 9558