StirlingBenefits®
Evolving the Business of Benefits℠

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 $_____

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 Plan sponsored by the Employer.

_____ _____

Signature ***Date***

Send this form and required documents to the address listed below or you can fax to (203) 877-9558 or email to hraclaims@StirlingBenefits.com