

**HRA CLAIM FORM**

For GDI Use Only

**College of the Atlantic**

Auditor:

**HRA Plan Year: January 1 through December 31**

Claim #:

Health Plan Renewal Date: January 1

**EMPLOYEE INFORMATION**

**Employee Name :** **SS #**

**PLAN PARAMETERS**

**Maximum Reimbursement:** \$400 single / \$700 family

**Eligible Expenses:** All medical, vision or dental expenses eligible under IRS Code Section 213(d)

**Eligible Participants:** Employee and IRS-defined dependents enrolled in the Anthem Blue Choice PPO Plan

**Claim Reimbursement Submit:** HRA Claim Form with Anthem Explanation of Benefits (EOB) or the itemized receipt or statement from the service provider

**QUALIFIED EXPENSES**

Provider Name	Service(s)/Item(s) Purchased	Services For (Name/Relationship)	Service Dates	Expense

**TOTAL:**

**Submit Claims to:** **Group Dynamic, Inc.**  
**Address:** 411 U.S. Route One, Falmouth, ME 04105  
**Email:** Claims@gdynamic.com **Fax:** 207-781-3841

I request reimbursement for my qualified medical expenses as itemized above. I certify that I incurred these expenses as a participant in the HRA 105 plan established by the employer named above and that these expenses must qualify for reimbursement under the terms of my employer's plan expenses and the Internal Revenue Code and cannot be claimed as credits or deductions on my personal income tax.

I understand that reimbursements from this plan are paid from my employer's HRA 105 Plan and I acknowledge that I am responsible for paying each provider for the medical services received. I have retained copies of the documentation enclosed with this request. I understand that materials submitted will not be returned to me.

**SIGNATURE:**

**DATE:**

*Reimbursement requests received before 12 Noon (ET) on Tuesday will be processed that week.*

*Requests received after 12 Noon on Tuesday will be processed the following week.*

**PHONE:** 207-781-8800 or 800-626-3539

**Website:** www.gdynamic.com

