

Health Reimbursement Arrangement Reimbursement Request Form

Check if New Mailing Address

Employee Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

**Mail completed form to: Midwest Insurance Brokerage
Attn: Reimbursement Processing
4 Systems Drive
Appleton, WI 54914**

Fax to: 1-920-731-1421 Email: claims@mibltd.com

Attach documentation for qualified expenses

	Expense	Date <small>(Month/Day/Year)</small>	Total Amount of Charge <small>Check box if monthly re-occurring expense</small>
1			<input type="checkbox"/>
2			
3			
4			
5			
6			
7			
	Total Reimbursement Request		\$

I certify to the accuracy of the above information and that the amount I am requesting for reimbursement will not be covered by any insurance plan or other FSA, HRA or HSA reimbursement plan. Expenses were incurred during my coverage period for me, my spouse or a dependent for whom I can claim as a personal tax deduction. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax return for any year. I will be reimbursed up to the total accrued annual schedule of benefits. Midwest Insurance Brokerage accepts responsibility for processing payment of the claim.

Signature: _____ Date: _____

If you have questions regarding your claim and/or processing, please contact Midwest Insurance Brokerage at 920-731-2100 or 800-456-3567