KALAMAZOO COLLEGE
1200 ACADEMY, KALAMAZOO, MI 49006
(HRA) HEALTH REIMBURSEMENT PLAN
REQUEST FOR REIMBURSEMENT

Employee name	
Address	
☐ Check if this is a new address	

City	State	Zip

HEALTH REIMBURSEMENT

Complete one line for each expense you wish reimbursed under the Health Reimbursement Arrangement.
Please attach documentation (BCBSM Explanation of benefits - EOB) as support for the claimed amounts.

SERVICE DATE	PROVIDER	In-network Deductible Amount	75% Reimbursement

TOTAL AMOUNT REQUESTED: $

READ CAREFULLY

The undersigned participant in the Plan certifies that all expenses, for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the **Kalamazoo College BCBSM 90% PPO Health Plan.** The undersigned fully understands that he or she cannot submit a claim for reimbursement unless the claim has been applied to the in-network deductible by BCBSM. If the expense is a non covered benefit under the BCBSM medical plan the expense is not eligible for reimbursement under the Health Reimbursement Plan. Checks will be mailed to the employee at the address on file.

Employee Signature	Date

Mail to: JFP Benefit Management, Inc. - P.O. Box 189 - Jackson, Michigan 49204
(800)-589-7660 or (517) 784-0535 or **Fax to**: (517) 784-0821

Jan08

HRA