Spousal Incentive HRA Participant Claim Reimbursement Form

Full Name:__________________ Social Security Number:__________ Date of Birth__________

☐ Change of Address | Home Address:__________________________________

Email:__________________________ Employer Name:__________________

Medical Care Expense #1 (A Copy of Your Explanation of Benefits is Also Required)

Date Incurred:__________ Expense Description:__________________________ Amount:________

Name of Service Provider:______________ Person for Whom Expense Incurred:______________

Medical Care Expense #2 (A Copy of Your Explanation of Benefits is Also Required)

Date Incurred:__________ Expense Description:__________________________ Amount:________

Name of Service Provider:______________ Person for Whom Expense Incurred:______________

Medical Care Expense #3 (A Copy of Your Explanation of Benefits is Also Required)

Date Incurred:__________ Expense Description:__________________________ Amount:________

Name of Service Provider:______________ Person for Whom Expense Incurred:______________

Medical Care Expense #4 (A Copy of Your Explanation of Benefits is Also Required)

Date Incurred:__________ Expense Description:__________________________ Amount:________

Name of Service Provider:______________ Person for Whom Expense Incurred:______________

Medical Care Expense #5 (A Copy of Your Explanation of Benefits is Also Required)

Date Incurred:__________ Expense Description:__________________________ Amount:________

Name of Service Provider:______________ Person for Whom Expense Incurred:______________

All plan communication pertaining to your account activity is provided solely via email and the www.NueSynergy.com website. It is important to notify NueSynergy if you change your email address

The undersigned participant 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 Medical Expense Reimbursement Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan.

Employee Signature:______________________________ Date:__________________

Fax, mail, or email completed forms and copies of bills, receipts to:

NueSynergy, Inc.
4601 College Blvd, Suite 280, Leawood, KS 66211
Phone: 913.653.8381 · Toll-Free: 855.890.7239 · Fax: 855.890.7238 · Email: customerservice@NueSynergy.com

For office use only: Date processed:_______ Amount Approved: ______ Amount Rejected:______ Reviewed by:___________