Health Reimbursement Arrangement (HRA)

Reimbursement for copayments for day surgery and hospital admissions

All employees who have elected health insurance through the Town of Boxford are automatically enrolled in the Health Reimbursement Arrangement (HRA). This plan is administered by a third party vendor, Benefits Strategies.

Contact Information:

www.benstrat.com Telephone: 888-401-3539

You may access the website and download reimbursement forms without setting up an online account. All forms must be faxed or mailed – there is no provision to submit online.

To download claim forms and direct deposit request form, please log on to www.benstrat.com Top right hand corner choose employee/participants tab – Health Reimbursement Arrangements. The next page will display an option for claim form and direct deposit form. Instructions for claim form:

Amount to be reimbursed is $150.00 in column 1

Date of Service in column 2

Description is Other – copayment – column 3

Person receiving service is column 4

Sign and date

Include copies of invoices or explanation of benefit form (EOB)

Please fax or mail these to address listed on claim form.

Claim forms and Direct Deposit forms are also available on Town of Boxford website – www.town.boxford.ma.us Departments – Payroll/Personnel

Health Reimbursement Arrangement Request Form

benefit strategies LLC

FAX: (603) 647-4668 (Max of 15 pages)
Address: PO Box 1300, Manchester, NH 03105-1300
E-Mail: Flexdept@benstrat.com

Employee Name: (First, Last) ______________________ Last 4 digits of SSN: ☐☐☐☐

Primary Phone: ______________________ Employer: ______________________

Email: ______________________

E-mail is required to receive important account notifications.

Fill out form completely, including signature, and fax or mail to Benefit Strategies at the address listed above. Incomplete and unsigned claims will be returned. Please limit the number of pages faxed to a maximum of 15 pages. Reimbursement requests should be for a minimum of $25 (unless using remaining account balance). Notifications will be sent via e-mail for claim confirmation, payment notification and denial letters. Claims will be applied to the earliest eligible plan year. **Please Note: Legislation recently enacted a law that mandates some OTC expenses will no longer be eligible for reimbursement under health FSA effective January 1, 2011.**

HEALTH REIMBURSEMENT ARRANGEMET EXPENSES

Amount to be Reimbursed	Service Date(s)	Description (Not all plans allow all descriptions below, please refer to your plan description for the details of your plan)	Person receiving product / service
$		☐ Deductible ☐ Inpatient Services ☐ Medical ☐ Coinsurance ☐ Outpatient Services ☐ Prescription ☐ Other (please describe): ____________	
$		☐ Deductible ☐ Inpatient Services ☐ Medical ☐ Coinsurance ☐ Outpatient Services ☐ Prescription ☐ Other (please describe): ____________	
$		☐ Deductible ☐ Inpatient Services ☐ Medical ☐ Coinsurance ☐ Outpatient Services ☐ Prescription ☐ Other (please describe): ____________	
$		☐ Deductible ☐ Inpatient Services ☐ Medical ☐ Coinsurance ☐ Outpatient Services ☐ Prescription ☐ Other (please describe): ____________	
$		☐ Deductible ☐ Inpatient Services ☐ Medical ☐ Coinsurance ☐ Outpatient Services ☐ Prescription ☐ Other (please describe): ____________	

$ __________ TOTAL Health Reimbursement Arrangement Requested

READ CAREFULLY: To the best of my knowledge and belief, my statements in this request for reimbursement are complete and true. I am claiming reimbursement only for IRS eligible expenses incurred by my legal dependents or myself (Domestic/Civil Union Partners are *not* IRS eligible dependents in most cases.) I certify that these expenses have not been and will not be reimbursed from any other source and will not be claimed as an income tax deduction.

EMPLOYEES SIGNITURE: (REQUIRED)		DATE:	

benefit strategies LLC

Direct Deposit Authorization Form

FAX: (603) 647-4668
Telephone: (603) 647-4666 or (888) 401-FLEX (3539)
Address: PO Box 1300, Manchester, NH 03105-1300
E-Mail: Flexdept@benstrat.com

Employee Name: (First, Last) _____ Last 4 digits of SSN: ☐☐☐☐

Primary Phone: _____ Employer: _____

Email: _____

E-mail is required to receive important account notifications.

REIMBURSEMENT POLICY:

PLEASE CONFIRM RECEIPT OF YOUR DIRECT DEPOSIT BEFORE WRITING CHECKS ON THESE FUNDS. BENEFIT STRATEGIES WILL NOT BE RESPONSIBLE FOR OVERDRAFT FEES ON YOUR ACCOUNT. If the direct deposit transaction fails, payment will be issued via check until the issue is resolved.

IT IS CRITICAL THAT THIS INFORMATION IS ACCURATE AND THAT CHECKING OR SAVINGS ACCOUNT IS INDICATED

I hereby authorize Benefit Strategies, LLC to deposit funds directly to my (please check one):

☐ Checking Account ☐ Savings Account

☐☐☐☐☐☐☐☐☐ AND ☐

9 Digit Routing Number — Bank Account Number

See sample check below to help locate your 9 digit routing number and your bank account number:

Account Holder's Name, Address, Etc.

Check #

Date: _____

Pay to the order of: _____ $ ☐

_____

9 Digit Routing Number Checking Account Number

READ CAREFULLY: I authorize Benefit Strategies and the financial institution listed above to initiate credit entries, and if necessary, debit entries and adjustments for any credit entries made in error to my account shown below. This authorization will remain in effect until one of the following occurs: Benefit Strategies receives written termination notification of direct deposit or the plan year ends.

EMPLOYEE'S SIGNATURE: (Required)		DATE:	