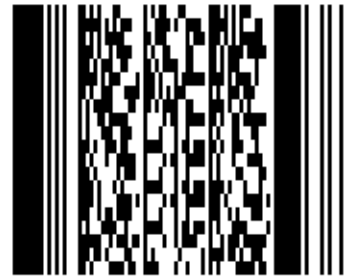




part of FuturePlan by Ascensus®

HRA Claim Form



##11BPC001#####

MAIL: PO BOX 56019
BOSTON, MA 02205

PHONE: 877-272-8880

ONLINE: https://bpc.wealthcareportal.com

FAX: 877-760-7076

Employer: _____

Participant Name (please print): _____

SSN: X X X - X X - _____

Day Time Phone Number(____) _____ - _____

Email Address: _____

I have **Changed** My Address to: _____

Street

City

State

ZIP

NOTE: Please do not send original documentation to BPC. All items submitted (receipts and otherwise) will be considered property of BPC and will not be returned to you. **The IRS has determined that cancelled checks, check carbons, balance forward or previous balance statements, as well as charge card receipts or statements are NOT acceptable documentation of expenses.** Expenses **MUST** have been incurred during the coverage period. All submitted bills/receipts/statement/EOB **must be itemized** with the date of service, service provided/or item purchased, and the amount charged. **All supporting documentation MUST be included**

Expense Description	Dates of Service (From—To)	Provider	Claimant/Patient	Amount of Purchase
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
				\$
AMOUNT REQUESTED:				\$



HRA = Health Reimbursement Arrangement

I have included supporting documentation from an independent third party verifying that the eligible expense(s) has/have been incurred in the amount of the listed expense. By my signature below, I certify that all of the expenses listed on this form are valid and eligible and have been incurred by myself and/or my spouse and/or my eligible dependents. The expense(s) has/have not been discounted via coupon, rebate or other discount program, nor reimbursed in any way, and I will not seek reimbursement. I understand that the expense(s) for which I am reimbursed may not be used as deductions or credits on my, or my spouse's, income tax return. If I have inadvertently received payment for an ineligible expense or have been incorrectly reimbursed, I agree to provide repayment to the Plan.

A signature is required on each claim form that is submitted.



Participant Signature: _____

Date Submitted: _____



www.bpcinc.com/mobile-app

www.mywealthcareonline.com/bpcinc

www.bpcinc.com/forms-participants