ZaneBenefits
Defined Contribution Employer Health Benefits

HRA Claim Submission Form

For fastest response, submit claims and proof of payments online at www.myZaneHealth.com.
(If you have an HSA-Compatible HRA, do not use this form; use the online claim form)

1 EMPLOYEE INFORMATION

Employee Name: _____ **Date of Submission:** _____

Employer / Company: Sherwood Management Co., Inc.

2 CLAIM INFORMATION

Complete the following for each expense submitted for reimbursement. Attach supporting proof of payments that verify that an expense has been incurred. Proof of payments must show the date of service, type of service, provider name, patient name, and amount paid.

Claim for Health Insurance Premium

If your claim is for the reimbursement of a personal health insurance premium, please complete the information below.

Time Period Covered by Premium	Person(s) Covered by Policy	Insurance Provider	Amount
___/___/_____ to ___/___/_____	_____	_____	$_____.___

Expense Codes: Please assign one of the following code numbers to each claim listed below

1. Pharmacy/Prescription
2. Dental
3. Vision
4. Physician / Doctor / Clinic
5. Preventative Care (e.g. annual exams)
6. Qualified OTC Drugs
7. Chiropractic Care
8. Alternative Medicine
9. Mental Health
10. Maternity/Prenatal Care
11. Hospital Care (excluding physician)
12. Smoking Cessation
13. Therapy (Physical, Occupational)
14. Weight Loss (Doctor-supervised)
15. Other (please specify)

	Date of Service	Employee / Dependent Name	Provider Name*	Expense Code (see above)	Amount
1	___/___/_____	_____	_____	_____	$_____.___
2	___/___/_____	_____	_____	_____	$_____.___
3	___/___/_____	_____	_____	_____	$_____.___
4	___/___/_____	_____	_____	_____	$_____.___
5	___/___/_____	_____	_____	_____	$_____.___
6	___/___/_____	_____	_____	_____	$_____.___

*List specific provider name (e.g. Dr. Jones, St. Luke's Hospital, RediClinic, Walgreens, Standard Optical, etc.)

3 SIGNATURE (Required)

I certify that, to the best of my knowledge and belief, the medical expenses listed above:

- Were incurred by me and/or my eligible dependents on the dates indicated.
- Have not been reimbursed by this HRA plan, and are/will not be reimbursed by any other insurance or health benefit plan.
- Are reimbursable under the terms and conditions of the health insurance, HRA, and/or other health benefit plans under which my eligible dependents and I are covered.

I request to be reimbursed for these amounts listed above from my HRA. By submitting this claim, I elect participation in the HRA.

Required **Employee Signature:** _____

4 CHECK LIST (Have you completed the following?)

- ☐ Completed Employee Information above (Section 1)
- ☐ Completed Claim Information above (Section 2)
- ☐ Signed This Form (Section 3)
- ☐ Faxed or mailed form with proof of payment to Zane Benefits

5 MAIL OR FAX INFORMATION

Fax to: 1-800-801-0787

Mail to: Zane Benefits
P.O. Box 684392
Park City, UT 84068-4392

Do you have Questions? Call Zane Benefits at 800-801-1716 or email help@zanebenefits.com

ZaneBenefits
Defined Contribution Employer Health Benefits

Claim Fax Cover Sheet

TO: Claims Processing
Company: Zane Benefits, Inc.
Fax: **1-800-801-0787**
Phone: 1-800-801-1716

FROM *(full name)*: _____
Company: Sherwood Management Co., Inc.
Phone: _____
Email Address: _____

Please Fax to 1-800-801-0787

Note/Comments:

CONFIDENTIAL

This document contains HIPAA protected personal health information. If you are not the intended recipient of this letter, please immediately deliver it to the intended recipient or contact Zane Benefits at 800-801-1716. Please do not read the contents.