Flexible Benefits Plan Claim Form: Please refer to important deadline dates to prevent claim denial

OFFICE USE ONLY: Claim Number:_____Rev 8/2024

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Employee Information

www.harrisonbenefits.org

Last Name (Print)	First Name	MI	Phone Number
Street Address	City	State	Zip
☐ Check if new address	Last 4 of Social Security Number		Date of Birth

Submit Claims To:
Harrison Flex Plan
PMB #116, 5331 S Macadam Ave, Ste 258,
Portland, OR 97239
Fax: (503) 208-9224
Email: pdxflexclaims@benesys.com

Patient Information

INSTRUCTIONS: Please provide claim patient information. Is the patient: ❑ Self ❑ Spouse ❑ Child ❑ Other. If other, specify: _____
NOTE: No patient information required when submitting Explanation of Benefits from insurance company.

Last Name	First Name	MI	Last 4 of Social Security Number	Date of Birth (mo/day/year)

Type of Claim

INSTRUCTIONS: Please mark the box for the benefit for which you are submitting a claim. Be sure to refer to your Benefits Booklet for eligibility requirements and for information on how to apply for each specific benefit.

☐ **Supplemental Workers' Compensation** **Deadline: Jan 15 for claims from previous year**	☐ **Supplemental Unemployment** **Deadline: Jan 15 for claims from previous year** ☐ **I've been working in Local: _____**	☐ **Benefit Dislocation** ☐ **First half of account** ☐ **Second half of account** **Deadline: Jan 15 for claims from previous year** ☐ **Where is your Home Local: _____**	☐ **Medical Care Reimbursement Plan** **Deadline: 12-mos from Date of Service** ☐ **This is a self-pay Premium reimbursement request**	☐ **Premium Pay Plan For Harrison Health Plan Coverage ONLY**	☐ **Dependent Care Reimbursement Plan** ☐ **Filing Jointly** ☐ **Filing Single** **Deadline: Jan 15 for claims from previous year**
You must provide proof of Workers' Compensation payment. Number of weeks requested _____ ***Taxable***	You must provide proof of unemployment payment. Date(s) and Number of weeks requested _____ ***Taxable*** Home Local _____	Home Local will verify eligibility. You are relocating to Local _____ @ Phone number _____ Address _____ _____ ***Taxable***	You must submit an Explanation of Benefits showing date and type of service. Amount requested: $_____ Dates From_____Thru _____	Amount requested: $_____ Partial Payment/Full Payment for Continued Health Coverage *No check generated	Please submit Dependent Care Expense receipts showing dates of service and name, address, and TAX ID number of person(s) performing the service. Amount requested: $_____

Signature of Participant

For Dependent Care Reimbursement: I certify that I have no other separate dependent care program through any employer. Please initial here:_____.
For Wage Replacement Claims: Please submit a W-4 form along with your claim. If you do not submit a W-4 form, taxes will be taken out based on taxes for a married person, filing jointly. Forms are available at www.harrisonbenefits.org or www.irs.gov.

I certify that I have read the instructions and that the above information is complete and accurate. I also certify that all claims submitted will be only for myself or for my dependents that are eligible for benefits under the plan. Additionally, I certify that there is no other coverage for my dependents or me provided by another insurance company or employer for the benefit that I am seeking coverage. I understand that I will be responsible to reimburse the Trust Fund for all amounts paid in connection with claims for me or my dependents if I make any false statements or misrepresentation in this form or in any claim form or if I conceal any information pertaining to any such claims. I agree to provide the Trust Fund, upon request, with verification of any information. I give permission to BeneSys, Inc. to examine records pertaining to myself or covered dependents as required to process claims.

_____

Signature of Employee

Date: _____