

**CITY OF DETROIT POST-2014 NON-SAFETY EMPLOYEE
RETIREE HEALTHCARE TRUST**

P.O. BOX 1497
TROY, MICHIGAN 48099-1497
(248) 641-4989

**Health Reimbursement Account (HRA)
Humana Authorization Claim Form**

Retiree's Name:	Retiree's SS# or Alternate ID:
Address:	City:
State:	Zip Code:
Phone Number (home):	Phone Number (cellular):
Email address:	

<u>Type of Service</u>	<u>Providers Name</u>	<u>Date of Service</u>	<u>Amount of Claim</u>
Medical Premium	HUMANA	2025	\$163.00

For questions regarding this form and the Humana Medical Premiums, please contact TMR & Associates at (313) 963-1135.

By completing and submitting this form I authorize BeneSys to deduct my Humana monthly premium, which is \$163, from my HRA account.

By signing this form, I understand that benefits shall be paid in accordance with the City of Detroit Post-2014 Non-Safety Employee Retiree Healthcare Trust.

Retiree's Signature: _____ Date: _____