

Flexible Benefits Plan Claim Form

OFFICE USE ONLY: Claim Number: _____



Employee Information				www.ourbenefitoffice.com/Harrison/Benefits/
Last Name (Print)	First Name	MI	Phone Number	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
Street Address	City	State	Zip	
<input type="checkbox"/> Check if new address	Social Security Number		Date of Birth	

Patient Information	INSTRUCTIONS: Please provide claim patient information. Is the patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other. If other, specify: _____ NOTE: No patient information required when submitting Explanation of Benefits from insurance company.						
Last Name	First Name	MI	Social Security Number	Sex	Date of Birth (mo/day/year)	Disabled	Full Time Student
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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.				
<input type="checkbox"/> Supplemental Workers' Compensation You must provide proof of Workers' Compensation payment. Number of weeks requested _____ Taxable	<input type="checkbox"/> Supplemental Unemployment You must provide proof of unemployment payment. Date(s) and Number of weeks requested _____ Taxable Local _____	<input type="checkbox"/> Benefit Dislocation <input type="checkbox"/> First half of account <input type="checkbox"/> Second half of account Local 48 will verify eligibility. You are relocating to Local _____ @ Phone number _____ Address _____ _____ Taxable	<input type="checkbox"/> Medical Care Reimbursement Plan You must submit an Explanation of Benefits showing date and type of service. Amount requested: \$ _____ Dates From _____ Thru _____	<input type="checkbox"/> Premium Pay Plan For Harrison Health Plan Coverage ONLY Amount requested: \$ _____ Partial Payment/Full Payment for Continued Health Coverage *No check generated	<input type="checkbox"/> Dependent Care Reimbursement Plan <input type="checkbox"/> Filing Jointly <input type="checkbox"/> Filing Single 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 <http://harrisonflex.aibpa.com> or <http://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 A&I Benefit Plan Administrators to examine records pertaining to myself or covered dependents as required to process claims.

 Signature of Employee _____
Date