Please attach the required documentation to this form and send to:
(See back of form for explanation of required documentation)
Stanley, Hunt, DuPree & Rhine
Post Office Box 6400
Greenville, SC 29606 OR

Fax number: 1-252-293-9048 or 1-252-293-9049 Number of pages in this fa
Email: shdrflexclaims@shdr.com

OPTIONS FOR OBTAINING ACCOUNT INFORMATION:
website www.shdr.lh1ondemand.com **1-800-930-2441 or 1-800-768-4873**
(Monday thru Friday 8:00 a.m.–8:00 p.m. ET)

Your Employer _____

Health Reimbursement Account (HRA) Claim Form

Employee Name: **Social Security Number:**

Daytime Phone Number: **Email:**

Based on your employer's plan specifics, supporting documenation must include the Explaination of Benefits (EOB) describing the expense listed below.

Provider Name	Person for whom Expense was incurred	Relationship	Date of Service	Description of Service	Amount Requested
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
					$
				Total Reimbursement Requested	**$**

Employee Certification

1. The health care expenses claimed above are not eligible for reimbursement by any insurance carrier or other employer-sponsored plan.
2. The expenses claimed above have not been and will not be taken as a credit or deduction on my personal income tax return.

Employee Signature_____ Date_____

Claims cannot be processed without the participant's signature and required supporting documentation