JFP Benefit Management, Inc.

(HRA) DEDUCTIBLE REIMBURSEMENT PLAN
REQUEST FOR DEDUCTIBLE REIMBURSEMENT

Employee Name		Contract/ID #
Address		
☐ Check if this is a new address		
City	State	Zip

DEDUCTIBLE REIMBURSEMENT

Complete one line for each expense you wish reimbursed under the Health/Deductible Reimbursement Account.

Please attach documentation (Blue Cross EOB) as support for the claimed amounts.

SERVICE DATE	PROVIDER	AMOUNT

TOTAL AMOUNT REQUESTED: $

READ CAREFULLY (Please keep copies for your records)

The undersigned participant in the Plan certifies that all expenses, for which reimbursement or payment is claimed by submission of this form, were incurred during a period while the undersigned was covered under the **Emmons Service, Inc.** medical plan**.** The undersigned fully understands that he or she cannot submit a claim for reimbursement unless the claim has been applied to the deductible by BCBSM. If the expense is a non covered benefit under the BCBSM medical plan, the expense is not eligible for reimbursement under the Deductible Reimbursement Plan. Checks will be mailed to the employee at the address on file.

Employee Signature	Date

Mail to: JFP Benefit Management, Inc. - P.O. Box 189 - Jackson, Michigan 49204
(800)-589-7660 or (517) 784-0535
Fax number: 517-784-0821
Email:cservice@jfpbenefitmanagement.com