Chittenden Central Supervisory Union

Health Reimbursement Arrangement (HRA)

Claim Form *Do Not Submit – expenses are automatically sent to Future Planning from Blue Cross Blue Shield of Vermont*

Name:	Social Security Number:

NOTE: This form is for health insurance deductible expenses only. Participants and their eligible family members (defined as a legally married spouse, partner and/or dependents) must be covered under the BC/BS Comprehensive group health insurance (aka:$1,200 Comp plan). Participants are required to attach a copy of the Explanation of Benefit (EOB) form from the health insurance plan when requesting a reimbursement.

Maximum Annual Dollar Benefit paid from the HRA:

Single: $1,200 2 Person/Family: $2,400

Health Insurance Plan deductible: $1,200 (single) or $2,400 (2 person/family) per year

Health Care Expenses Eligible for Reimbursement:
Health Insurance Deductible Expenses

Expenses must be incurred while you were a participant during the Coverage Period - January 1 – December 31 thereafter

LIST TOTAL EXPENSES

(additional space available on page 2)

Date Incurred	Person for Whom Expense is Incurred		Charge
Total Amount Claimed (pages 1 and 2)			

The undersigned participant in this Plan certifies that all expenses for which payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Plan and have not otherwise been reimbursed through insurance, or from any other source and will not be claimed as a federal income tax deduction. The undersigned further understands that he or she is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim.

Signature:	Date:

Mail completed form to: Future Planning Associates, Inc.
ATTEN: Chittenden Central Supervisory Union Plan Administrator
P.O. Box 905
Williston, VT 05495
Phone: (802) 857-0698; E-mail: linda@futureplanningassoc.com
FAX: (802) 857-0718; if Faxing this request, to avoid duplication, DO NOT mail.

This form must reach Future Planning Associates by noon every other Tuesday
Disbursements will be paid the following week

Date Incurred	Person for Whom Expense is Incurred	Charge

EMPLOYEE AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT OF HEALTH REIMBURSMENT ARRANGEMENT REIMBURSEMENTS

I hereby authorize and request that Future Planning Associates, Inc. (contracted by Chittenden Central Supervisory Union to provide administration services for the Chittenden Central Supervisory Union Health Reimbursement Arrangement (HRA) to make payment of any Chittenden Central Supervisory Union Health Reimbursement Arrangement (HRA) Claims Reimbursement of any amounts to me by initiating credit entries to my account indicated below in the bank named below, hereinafter called BANK, and I authorize and request BANK to accept any credit entries initiated by Future Planning Associates, Inc. to such account and to credit the same to such account without responsibility for the correctness thereof.

I also authorize Future Planning Associates, Inc. to adjust any over deposits erroneously credited to my account if prior to the initiation of the correcting entry, Future Planning Associates, Inc. has sent or delivered to me written notice of the correction.

It is understood that this agreement may be terminated by me at any time by written notification to Future Planning Associates, Inc. Any such notification to Future Planning Associates, Inc. shall be effective only with respect to entries initiated by Future Planning Associates, Inc. after receipt of such notification and a reasonable opportunity to act on it. Any such notification to BANK shall be effective only with respect to entries credited to my account by BANK after receipt of such notification and a reasonable time to act on it.

I recognize, acknowledge and accept that this service is being provided for my convenience. As such, I agree not to hold Chittenden Central Supervisory Union and or Future Planning Associates, Inc. liable for errors made by them or the financial institution.

ATTACH A VOIDED CHECK OR DEPOSIT SLIP FOR SAVINGS ACCOUNTS and RETURN WITH YOUR FIRST CLAIM SUBMISSION

Name of Bank or Credit Union ***** _____

Account # _____ Routing # _____

***** Contact your Credit Union to verify your "Account" and "Routing" Numbers

Account Type: _____ Checking **(attach a voided check only, a deposit slip does not provide sufficient information)**
_____ Savings **(attach a deposit slip)**

Employee Name (Print)_____

Employee Signature: _____

Employee e-mail: _____

NOTE: Any changes in Bank or Account Numbers must be made in writing and sent to:

Chittenden Central Supervisory Union Plan Administrator
Future Planning Associates, Inc.
P.O. Box 905
Williston, VT 05495-0905

Phone: (802) 857-0698 **FAX:** (802) 857-0718

Chittenden Central Supervisory Union
Health Reimbursement Arrangement

Personal Information

WE NEED THE FOLLOWING INFORMATION FOR ALL EMPLOYEES PARTICIPATING IN HEALTH REIMBURSEMENT ARRANGEMENT. **DUE TO PRIVACY ISSUES, WE WILL ONLY DISCUSS YOUR ACCOUNT WITH YOU UNLESS YOU HAVE RETURNED THIS COMPLETED FORM.**

YOUR NAME:	
MAILING ADDRESS:	
CITY, STATE, ZIP CODE:	PHONE:
E-MAIL :	

MARITAL STATUS:
(PLEASE CIRCLE) **SINGLE** **MARRIED** **CIVIL UNION*** **DOMESTIC PARTNER***

*** Due to Federal Income Tax Regulations, expenses for Civil Union and Domestic Partners are <u>not</u> eligible for <u>tax-free</u> reimbursements under a Health Reimbursement Arrangement (HRA) unless the partner is considered a dependent and claimed as such on your federal income tax return.**

<u>List all eligible dependents, civil union or same-sex married partner or spouse</u>
(reimbursements for civil union and domestic partners' expenses are considered federal taxable income)

FULL NAME ***(DO NOT INCLUDE YOURSELF)***	**Date of Birth**	**M/F**	**Relationship To You**
JOHN/JANE DOE	00/00/00	M/F	SPOUSE/PARTNER

If the status of your spouse or dependent changes during the plan year as your spouse or dependent, including a new spouse or dependent, you must contact the plan Administrator with these changes immediately.

Those named above, are ___, are not ___ (check one) authorized to discuss the status of my Health Reimbursement Arrangement, including payments of benefits, with Future Planning Associates, Inc.

SIGNATURE:	DATE:

PLEASE SIGN AND RETURN THIS FORM TO FUTURE PLANNING ASSOCIATES WITH YOUR FIRST CLAIM