

# Southeast Dubois County School Wellness *Benefit Claim Form*

**Part 1**

*Please type or print clearly*

Employee's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone#: \_\_\_\_\_

**Part 2**

**SIGN/DATE**

I certify that the expenses for which wellness HRA credit is requested under the Wellness Benefit were incurred by myself. I further certify that these expenses are not reimbursable under any other plan, including a plan of another employer that covers me.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**Part 3**

**ELIGIBLE EXPENSES**

Covered expenses you have paid (attach verification and if applicable, proof of attendance).

Description of Eligible Expenses	Person Incurring Expense	Date of Service	Total Amount of Bill
			\$
			\$
			\$
			\$

x 100%

**TOTAL HRA CREDIT REQUESTED:**  
(100% of total amount of bill)

\$
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Send Claim to: Dunn & Associates  
Attn: Kerilyn Lepper  
P.O. Box 2369  
Columbus, IN 47202-2369