Southeast Dubois County School

Wellness Benefit Claim Form

FAX TO: (812) 378-9967

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) $

Or SEND CLAIM TO:

Dunn & Associates
Att: Carla Skidmore
P.O. Box 2369
Columbus, IN 47202-2369
carla.skidmore@dunnbenefit.com