Compass Rose PS HRA Plan Reimbursement Voucher

First Financial Administrators, Inc.



EMPLOYEE INFORMATION (Please Prin	ADDRI	ESS CHANGE?	Π Υ	N			
FIRST NAME	MI	LAST N	LAST NAME SS		l		
ADDRESS			CITY		STATE	ZIP	
PHONE (Between Hours of 8am-5pm)		EMAIL A	DDRESS				
PLAN INFORMATION	ľ						
Compass Rose PS is providing employees a HRA a Health Reimbursement Arrangement							

family coverage. This money can only be used for co-insurance, deductible expenses and prescription medications. You must file your Explanation of Benefits from your health plan along with this claim form. The plan year is September 1 - August 31. You have 90 days at the end of the plan year to file your claims and any unused funds will not rollover.

HRA EXPENSES

DATE OF SERVICE	FAMILY MEMBER	DESCRIPTION OF EXPENSE	AMOUNT

Additional vouchers can be obtained by logging onto our website, www.ftga.com.

Mail or Fax Completed Form To:

First Financial Administrators, Inc. • P.O. Box 161968, Altamonte Springs, FL 32716 Fax Number: 1-800-298-7785

EMPLOYEE SIGNATURE (*REQUIRED*)

I hereby affirm that, to the best of my knowledge, all expenses listed above are eligible for reimbursement under Section 105 of the IRS Code. I further certify that these expenses have not been, nor will not be, reimbursed under any other health plan coverage. NOTE: If you have direct deposit, First Financial Administrators, Inc. will not pay bank charges for Insufficient funds. Please call your financial Institution to verify deposit before writing any checks on the amount. If you need verification of the eligibility of an expense, please contact First Financial Administrators, Inc. at 1-866-853-3539.

EMPLOYEE SIGNATURE:

DATE

First Financial Administrators, Inc. • PO Box 161968 • Altamonte Springs, FL 32716 • Phone: 866-853-3539 • Fax: 800-298-7785