SOUTHERN TIER ENVIRONMENTS FOR LIVING, INC.
HRA DEDUCTIBLE REIMBURSEMENT FORM

- Please complete this form and attach the Explanation of Benefits (EOB) from the insurance company.
- **If the Explanation of Benefits is not included, your request for reimbursement cannot be processed.**
- Mail, fax, or email this form directly to Beneflex, Inc. at 1030 State St, Suite 2, Erie, PA 16507 or
- fax: (814) 461-6590 or email claim to: beneflex@nwbcorp.com
- Questions: (814) 453-3107 Toll-free (800) 454-3107

Last 4 Digits of Social Security # ____________ Daytime Phone # ______________________________

Employee's Name ____

Address: ____

DESCRIPTION OF EXPENSES AND REIMBURSEMENT AMOUNT REQUEST:

Patient's Name	**Relationship**	**Date of Service**	**Service Provider**	**Deductible Expense**	Check here to have other expenses reimbursed through your Flexible Spending Account

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

- I certify that the expenses listed on this form are eligible for reimbursement pursuant to the provisions of the STEL Health Reimbursement Arrangement.
- I certify that the deductible is not eligible for reimbursement by any other benefit plan, and that I will not include these expenses as itemized deductions on my personal income tax returns.
- If I checked the box to have my balance deducted from my FSA, I certify that the expenses are eligible for reimbursement under the FSA, and are not eligible for reimbursement by any other benefit plan. I understand and agree that I am solely responsible for determining the validity of the expenses for which I am requesting reimbursement.

Employee's Signature ________________________________Date ____________

The employee is responsible for provider payment. Retain one copy for your records.