TCC Benefits Administrator℠

4400 Leeds Avenue, Suite 130
North Charleston, SC 29405
Phone: 800.815.3314
Fax: 843.722.2866
www.tccba.com

Health Reimbursement Arrangement Claim Submittal Form

Employer: _____

Employee Name: _____ Social Security #: _____

Phone: _____

Health Reimbursement Arrangement Expense Claims				
Date Expense Incurred	**Name of Service Provider**	**Expense Description**	**Person for Whom Expense Incurred**	**Net Amount**
⇨ *Attach appropriate explanation of benefits and submit with this claim form.*		**Total Health Reimbursement Arrangement Expense Claim**		

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Health Reimbursement Arrangement (HRA) with respect to such expenses and that the medical expenses have not and will not be reimbursed under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which related to such expense.

_____ _____

Employee's Signature Date

Attached your Explanation of Benefits (EOB) for reimbursement and Mail or Fax Claim Form to:

TCC Benefits Administrator
PO Box 63477, North Charleston, SC 29419

Or you may contact:

Page Murphy
pmurphy@tccba.com
Phone: (800)815-3314 ext 250
Fax (803) 264-4197

Delivering Creative Benefit Solutions for Business