SECTION 125 FLEXIBLE SPENDING

HRA/HSA Claim Form

Instructions: Please complete this form for the submission of any EOBs or receipts. Number your EOBs and receipts to correspond with the "Item #" column in sections B, C, and/or D. Fax form to (512) 719-6505 or mail form to TML IEBP. This form must be submitted with each EOB or receipt; claims will not be processed unless proper documentation is supplied. Pleae Note: Section B applies only to plans in which HRA/HSA Funds are available after meeting an HRA/HSA deductilbe. For more information about your plan, consult your enrollment materials, your HR Department or TML IEBP.

A. Account Holder Information*

NAME Last	First	Middle Initial

MAILING ADDRESS Street	City	State	Zip

Social Security Number	Employer
- -	
Daytime Phone Number	E-mail
( ) -	

B. EOBs for Proof of Deductible (necessary only for plans in which HRA Funds are available after meeting an HRA Deductible)

To meet your HRA Deductible and have access to your HRA funds, you must first submit EOBs to report your spending. Please complete the following section for any EOBs you wish to submit. *You must first meet your HRA Deductible before you can be reimbursed from your HRA funds.*

Item #	Date	Provider
E1	/ /	
E2	/ /	
E3	/ /	
E4	/ /	
E5	/ /	

C. Receipts For Reimbursement

Please complete this section for any requests for manual reimbursement from your HRA funds. You must provide a corresponding receipt in order to be reimbursed.
NOTE: You may have to meet an HRA Deductible (see Section B above) before you are eligible for reimbursement. Consult your HR Department or TML IEBP for info about your plan.

Item #	Date	Provider	Amount
R1	/ /		
R2	/ /		
R3	/ /		
R4	/ /		
R5	/ /		

Will this reimbursement be made via direct deposit? ☐ Yes ☐ No Total Amount For Reimbursement

D. Receipts For Pharmacy Purchases

Please complete this section to accompany pharmacy receipts. You must provide receipts for all pharmacy purchases.

Item #	Date	Provider	Amount
P1	/ /		
P2	/ /		
P3	/ /		
P4	/ /		
P5	/ /		

E. Agreement and Signature*

I certify that these eligible expenses have been incurred by me or my eligible dependent and are not for cosmetic purposes but for the treatment of an illness, injury, trauma, or medical condition. I understand that expense incurred means the service has been provided that gave rise to the expense, regardless of when I am billed or charged for or pay for the service. The expenses have not been reimbursed and I will not seek reimbursement elsewhere. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I understand that I am not eligible for reimbursement before I have reached the HRA Deductible set by my employer. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions.

	Employee signature	Date
		/ /

MAIL TO:	FAX TO:	
TML IEBP PO Box 140167 Austin, Texas 78714-0167	TML IEBP (512) 719-6505	Please keep copies of all receipts and EOBs for your own records. For questions and concerns, please call TML IEBP at (800) 282-5385.

* These sections are required. Use only Sections B, C, and D as needed.