Health Reimbursement Arrangement
Reimbursement Claim Form

To expedite your claim:
- ◆ Provide *all* appropriate information
- ◆ Expense amounts before printing

Employer: Paragon Press Inc.

Employee Name:_____ Social Security #: _____

Phone: _____ E-mail: _____

Fax completed form to: (801) 571-9173, email to kkats@hbni.com or mail to: 10542 S. Jordan Gateway Suite 100 South Jordan, UT 84095
Kathy Katsanevas, Nielsen Benefits Group, Tel: (801) 571-0817

Healthcare Expense Claims

Date Expense Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	
◆ Attach appropriate EOB's (Explanation of Benefits) and submit with this claim form.				$ $0.00

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 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 relate to such expense.

Your Health Reimbursement Arrangement (HRA) Plan may be limited to the types of healthcare expenses that may be reimbursed to you. Please read the Summary Plan Description of your HRA Plan for a list of eligible expenses.

_____ _____

Employee's Signature Date