



City of Detroit Police & Fire Retiree Healthcare Trust

Troy Office (248) 641-4932 Toll Free (833) 725-5336

Health Reimbursement Account (HRA) Claim Form - 2026

*You will need to submit new HRA Reimbursement Forms for 2026, your HRA recurring payments do not carry over from year to year.
See Back for Instructions*

Select One Box Only:

☒ Withdraw from Retiree Account: Joe Friday SSN or Alternate ID: xxx-xx-0000

☐ Withdraw from Spouse Account: _____ SSN: _____

Address: 700 Tower Drive City: Troy State: MI Zip: 48098

Phone Number: (Home) _____ (Cellular) _____

Person Receiving Service: Joe Friday Relationship: Self

Insurance Premium Reimbursement - A copy of a paid monthly premium invoice, payment history from your insurance provider or your monthly pension stub (may be submitted as recurring expense)

Recurring Premium Reimbursement Claim for January 2026 – December 2026	Provider's Name	Amount of Claim (Claim total must exceed \$25)
	Medicare Part B Premium	\$206.50
	Delta Dental	\$39.27
	VSP Vision	\$11.50

Medical Co-payments/Services - Copy of your Explanation of Benefits Form (EOB) or copy of invoice listing provider name, date of service, recipient of service, description of service and the amount owed by recipient.

Dental Services - Copy of invoice listing provider name, date of service, recipient of service, description of service and the amount owed by recipient.

Cost estimate statements are not acceptable.

Vision Services - Copy of invoice listing provider name, date of service, recipient of service, description of service and the amount owed by recipient.

Prescription Co-Payment - A copy of the drug label stub or a printout from your pharmacy. *Cash register receipts are not acceptable.*

Type of Claim (Medical, Dental, Vision, RX)	Provider's Name	Services Rendered	Date of Service	Would you like monthly payments until paid in full? (Y/N)	Amount of Claim (Claim total must exceed \$25)

By signing this form, I acknowledge that the information provided above is true and accurate and that I have not been and will not be reimbursed for the expenses listed above from any insurance company, flexible benefit plan, health savings account (HSA), another HRA, or any other source. I further understand that benefits shall be paid in accordance with the Retired Detroit Police & Fire Fighter Health Care Plan.

Signature of Retiree or Spouse as applicable: Joe Friday Date: 01/01/2026

HRA Claims must be filed by March 31st of the year following the Plan Year in which the expense was incurred. Claims filed following the March 31st deadline will be denied by the Plan's Third-Party Administrators as untimely.

- Example: Date of Service in 2025, claim must be filed by March 31, 2026
- Example: Date of Service in 2026, claim must be filed by March 31, 2027

To receive benefits from your HRA account, you must complete ONE FORM per claimant, along with the required supporting documents and mail to COD Police & Fire RHT, P.O. Box 1198, Troy, MI 48099-1198 fax to (248) 636-4193 or emailed to CityofDetroitPFHRAclaims@benesys.com.