City of Detroit Police & Fire Retiree Healthcare Trust

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

Health Reimbursement Account (HRA) Claim Form - 2025

You will need to submit new HRA Reimbursement Forms for 2025, your HRA recurring payments do not carry over from year to year.
See Back for Instructions

Select One Box Only:

☐ **Withdraw from Retiree Account:** _____ SSN or Alternate ID: _____

☒ **Withdraw from Spouse Account:** Molly Williams SSN: xxx-xx-0000

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

Phone Number: (Home) _____ (Cellular) _____

Person Receiving Service: Molly Williams 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 2025 – December 2025	**Provider's Name**	**Amount of Claim** *(Claim total must exceed $25)*

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)*
Medical	Dr. Oz	Annual Exam, Lab Work, X-Rays	1/1/2025	Y	$640.00
RX	Meijer	Prescription	1/1/2025	N	$10.00
Vision	Vision Center	Glasses	1/1/2025	Y	$440.00

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: Molly Williams Date: 01/01/2025

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 2024, claim must be filed by March 31, 2025**
- **Example: Date of Service in 2025, claim must be filed by March 31, 2026**

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*.