



MAJCO, LLC dba Big Brand Tire & Service
 For claims incurred 1/1/2025 through 12/31/2025

Health Reimbursement Arrangement Claim Form

- Employee Only \$6,000 Max Medical Out-of-Pocket**
 1st \$1,200 paid by Employer
 2nd \$4,800 paid by Employee
- Family Coverage \$12,000 Max Medical Out-of-Pocket**
 1st \$1,200 paid by Employer per family member (x2)
 2nd \$4,800 paid by Employee per family member (x2)
 (Min of 2 family members required to meet family deductible)

Note: The HRA reimburses out-of-network claims up to the in-network amount only. The eligible expenses under the plan are all the medical max out-of-pocket expenses incurred from your group health plan like deductible, coinsurance, office visit copays and prescriptions.

EMPLOYEE INFORMATION

Name: _____ Social Security#: XXX – XX - ____ _
 Address: _____ Company Name: _____
 City/State/Zip: _____ Daytime Phone Number: _____

Please check box if address is new

MANDATORY SPOUSE/DEPENDENT INFORMATION*
 (If claim is for spouse/dependent)

Name: _____ Social Security#: XXX – XX- ____ _
 Date of Birth _____ Gender: _____

Detail of Request

Date of Service Must be Itemized	Name of Service Provider	Expense Description	Person for whom the expense was incurred*	Enter the dollar amount
Total Amount Requested: _____ →				

Please attach (EOB) Explanation of Benefits in order listed above.

The undersigned participant in the Plan certifies all expenses for which reimbursement or payment is claimed were incurred during the current period under the company's HRA Plan. The undersigned fully understands he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all the information relating to this claim and certifies in advance of the transaction that any expense paid through the HRA has not been reimbursed and that the participant will not seek reimbursement from any other plan covering health benefits.

 Employee's Signature (must be signed for proper processing)

 Date

Paylocity
 Secure Email: batinfo@paylocity.com
 Phone: (800) 631-3539
 Fax: (314) 909-6983
 Mail: Benefit Administration Technologies Inc, PO BOX 7410394, Chicago, IL 60674-0394

Return this form along with all supporting document to Paylocity or submit your claim via the Employee Portal or Mobile App.

To be reimbursed you must submit your **(EOB) Explanation of Benefits** from your insurance carrier.

Example of How an HRA Works

1. Employer sets up an HRA-a promise to reimburse a portion of the medical expenses. Employer decides how much to contribute and when funds are available for the employee to use.
2. Participant has a qualifying medical event.
3. Insurance Carrier receives medical bill and creates an Explanation of Benefits (EOB).
4. Insurance Carrier sends EOB to Participant.
5. Participant sends claim form and EOB to Paylocity.
6. Participant receives reimbursement from Paylocity.
7. Participant pays the Provider.

Facts for Your Reference

- If you terminate employment, any expenses **incurred** after your termination date are not eligible for reimbursement. Medical Expenses can still be claimed if you continue your participation under COBRA.
- All claims must be signed and dated.
- Submit your claim via the Employee Portal or Mobile App or email, mail or fax us your claim along with all supporting documentation.
- If you fax your claim, keep a copy of the confirmation statement in case Paylocity does not receive your paperwork.
- Please itemize each (EOB) Explanation of Benefits on your claim form.

For questions, contact the Paylocity Customer Service Team at (800) 631-3539 or email batinfo@paylocity.com