FORMULA BENEFITS
Dental - Medical - FMLA - STD - COBRA - HRA
www.formulabenefits.com

Questions about this form?
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(651) 686-0108 ext. 106

Return completed form to:
Formula Corporation
Medical Reimbursement Plan
2919 Eagandale Blvd., Ste. 120
Eagan, MN 55121
Fax: 651-686-0513

MEDICAL REIMBURSEMENT PLAN (MRP) FORM

PERSONAL INFORMATION

Please fill out personal information below with the most current address, phone number, and email address. Please note all information is updated accordingly and stored securely.

Name: _____ Relationship to Policy Holder: ☐ Self ☐ Dependent

Employer: _____ Social Security Number: _____

Birthdate: _____ Primary Phone Number: _____

Email Address: _____

Address: _____
Address City, State, Zip Code

REIMBURSEMENT REQUEST

Please note which year you are requesting reimbursement for and your coverage type.

MRP Year Requested: _____ Coverage Type: ☐ Single ☐ Family

REIMBURSEMENT INFORMATION

To claim reimbursement on eligible expenses:

- **Complete the MRP form with all information requested**
- **Attach most recent Explanation of Benefits, including the 'Account Summary' page which states how much of your total deductible has been met**

You are eligible for the MRP reimbursement if:

- **Your total year-to-date deductible has surpassed $1,800.00 (single coverage)**
- **Your total year-to-date deductible has surpassed $3,600.00 (family coverage)**

SIGNATURE

I hereby certify that the information shown above is true and correct, and that neither I, nor any of my eligible dependents will receive reimbursement from any other source, and furthermore, that I have not, and will not claim any of these expenses as a deduction on, or in calculating a credit from my/my spouse's income taxes. In addition, I certify that the person listed above is eligible to be covered under the Plan.

_____ _____
Signature Date