County of Sonoma
HRA Premium Reimbursement Auto-Pay Request

Sign the form and submit it to P&A Group **Fax:** (877) 855-7105 **Mail:** P&A Group 17 Court Street Suite 500 Buffalo, NY 14202

If you would like to sign up for recurring claim reimbursement please complete the form below. A copy of a contract/ statement from the provider must be attached. Your payment statement/contract should contain your out-of-pocket costs (paid by you on a post-tax basis) for your monthly premiums. By signing for recurring claim reimbursement, you will not need to send claim requests for reimbursement during the plan year. This form must be completed at the beginning of each plan year in which you participate. Any changes to the below information must be reported to P&A immediately.

Employee Information

Company Name			
Employee Last Name		**Employee First Name**	
Social Security Number	**Home Phone Number**	**Work Phone Number**	**E-mail Address**
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Service Provider Information

Provider	Provider Premium	Rate Effective Dates*
	The provider charges a set amount of: ________ (Monthly)	From: ______ to ______

**If there is a change to your provider, service dates or rates, it is your responsibility to keep us informed of these changes and a new contract must be submitted to P&A immediately.*

I certify that the above listed provider premium have been incurred by me, my spouse or my legal tax dependents and that they have not been reimbursed under any other health plan; furthermore, will not seek reimbursement of the expenses under any other health plan. I further certify that if the above listed expenses have been incurred by my registered domestic partner, I have delivered to the plan sponsor my Certification of Federal Tax Dependent Status and Election of HRA Coverage for Your Domestic Partner.

Employee or Retiree Signature Date / /

PLEASE NOTE: Your submission must include a signed P&A claim form, your payment statement/contract and this form.