GLP-1 For Weight Loss HRA Reimbursement Request Form

Lifetime Benefit Solutions

Employer name: _____

Participant name (First, MI, Last): _____

Social security number: _____

Address: _____

City, ST, Zip: _____

Date of birth: _____ Phone number: _____

Note: This form should only be used if your HRA only reimburses GLP-1 medication for weight loss. If your HRA reimburses other expenses outside of GLP-1 medications, please use the "Reimbursement Request Form" available at **LifetimeBenefitSolutions.com**.

Please notify your employer of any address change. Lifetime Benefit Solutions will not make address changes from this form.

Claimant name	Date of service	Amount	Type of services/Items purchased	Claim reference number
John Sample	*4/1/2026*	*$150.00*	*Ozempic*	*Example*
				01
				02
				03
				04
				05
				06

Your employer may offer additional benefit plans through Lifetime Benefit Solutions. The use of this form is limited to reimbursement under an HRA that only allows reimbursement for GLP-1 medication for weight loss.

Your receipt must clearly show the cost of the medication as a stand-alone item. Costs associated with any weight loss program, office visit or any other services are not eligible for reimbursement under this HRA.

By submitting this form to Lifetime Benefit Solutions, I certify the information is accurate, the expenses incurred were for myself, spouse or qualified dependents, and these expenses are not reimbursable under any other plan coverage. In addition, I have read the Reimbursement Request Instructions on the following page and agree to adhere to all terms specified. I understand if I do not follow the instructions my reimbursement may be delayed or denied.

Submission Options (choose only one)

Online: Login to your consumer portal at **LifetimeBenefitSolutions.com/Members/Login**

Mail: Lifetime Benefit Solutions Claims Dept.
P.O. Box 211126
Eagan, MN 55121

Fax: (877) 256-7228

Should you have any questions, please contact our Customer Service Team at **(800) 327-7130**

Reimbursement Request Instructions

- For faster reimbursement processing, you may be able to submit your claims online at **LifetimeBenefitSolutions.com**.
- Complete the top section, including Social Security Number or Employee ID.
- Submit cost of the medication per row. Please note, receipt must clearly detail the cost of medication with no other associated fees.
- Label the receipts to correspond to the Claim Reference Number.
- If you have more items than the form can accept, use additional forms.
- Do not "lump" or group items together or write See Attached.
- All claims are subject to deadlines, as defined in your Summary Plan Description (SPD).
- The expenses you submit must qualify as valid expenses under the terms of the Plan, and the claimant receiving the services must be a qualifying individual as defined in the Plan.
- Retain a copy of the Reimbursement Request Form and receipts for your own personal records.
- Call Lifetime Benefit Solutions Customer Service with questions at **(800) 327-7130** during standard weekday business hours.

Claims For Reimbursement

- For each medical claim covered by your insurance carrier, submit an Explanation of Benefits (EOB). If your claims are not submitted to your insurance carrier, provide an itemized bill showing: date of service, provider name, patient name, charged amount, and description of services rendered.
- Do not send credit card receipts, original receipts, or cancelled checks.

Lifetime Benefit Solutions

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