AblePay
SIMPLE HEALTH SAVINGS

Telephone: 484-292-4000 **Fax:** 610-706-6120 **Email:** support@ablepayhealth.com

Address: PO Box 1278, Bethlehem, PA, 18016

Please fill out the information below for HRA reimbursement. This application is only for individuals and families that are not signed up for AblePay Health.

In order to accurately process your direct reimbursement you are required to provide complete demographic information for you and any dependents. Please fax, email or mail directly your Explanation of Benefits (EOB) with this attached cover sheet for direct employee reimbursement. AblePay will pay the employee directly with a check mailed to the address listed on this form.

INDIVIDUAL INFORMATION

First Name _____ Last Name _____

Date of Birth _____ Gender _____
(MM/DD/YYYY)

Address 1 _____

Address 2 _____

City _____ State _____ Zip _____

Email Address _____

Phone Number _____

DEPENDENT INFORMATION

First Name _____ Last Name _____ Date of Birth _____
(MM/DD/YYYY)

First Name _____ Last Name _____ Date of Birth _____
(MM/DD/YYYY)

First Name _____ Last Name _____ Date of Birth _____
(MM/DD/YYYY)

First Name _____ Last Name _____ Date of Birth _____
(MM/DD/YYYY)

First Name _____ Last Name _____ Date of Birth _____
(MM/DD/YYYY)