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Section 125 Flexible Benefit Plan

HEALTH CARE REIMBURSEMENT REQUEST

"Please Print"

Name of Employer:	
Name of Employee:	SSN: (*required*) - -
Address:	Address Change: Yes No
City/State/Zip:	Email Address:

Expense Information - Please Print

Please complete the following information **and** attach the required substantiation for each medical expense for which you are requesting reimbursement. Required claim substantiation is as follows:

- For expenses/services that apply to a Deductible and/or Co-Insurance (90/10, 80/20, etc.) the Explanation of Benefits (EOB) provided by your insurance company is required.
- For flat rate non-varying office visit/prescription Co-Payments ($15, $25, $35, etc.) a statement/receipt from your service provider that clearly identifies your out-of-pocket expense as a Co-Payment is required.
- For expenses/services that are **not** covered by **any** insurance policy a statement/receipt from your medical service provider that clearly identifies your total out-of-pocket expense is required.

All attached substantiation **MUST** include: date of service, provider of service, itemization of service rendered, and amount charged
If you have multiple receipts for a similar type of service, you may combine them on one line (example: five prescription co-pays).

Dates of Service	Amount Requested	Provider Name	Type of Service
__/__/__ to __/__/__	$______	______	______
__/__/__ to __/__/__	$______	______	______
__/__/__ to __/__/__	$______	______	______
__/__/__ to __/__/__	$______	______	______
Total Amount Requested	$______	only those expenses **incurred** prior to the date of this request will be processed	

Participant Acknowledgement: Reimbursements will only be made for expenses incurred **prior** to the date of the Reimbursement Request. An expense is considered **incurred** when the service is provided not when you make payment to your provider. Reimbursements will only be made when accumulated claims exceed $25.00. The $25.00 requirement is waived at the end of the plan year. All payments and correspondence will be issued directly to you. Receipts and/or statements **must** include **date of service**, **itemization of service**, **provider of service**, **and amount charged**.
I hereby certify that this information is, to the best of my knowledge, correct and that I have not or will not be reimbursed by any other health plan or program nor will the expense(s) be used as basis for a tax deduction. Claim documentation cannot be returned – please keep copies for your records.

Employee Signature: ______________________ **Date:** ____________

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