

*Please Read Carefully*

## **CLAIM FILING INSTRUCTIONS**

### **Who Can File A Claim Form**

- Only employees participating in the Cafeteria Plan can file a reimbursement claim form.
- Employees can file a claim form during the plan year and for a certain period after the plan year, if allowed by the plan. Please see your Summary Plan Description.

### **What Expenses Can Be Claimed**

- Only expenses for services incurred during the plan year can be claimed for reimbursement. Each year is treated separately, and the year of the claim is the year the service was actually incurred by the participant. It is imperative to send separate claim forms for each year.

### **Completion Of The Claim Form**

- Complete all information on the claim form for each amount claimed for reimbursement.
- Make sure the claim does not include items for more than one plan year. Use a separate claim form for different years.
- You must sign and date the form.
- Expenses must be substantiated as explained in the "Documentation Requirements For Flexible Spending Account Claims Substantiation."

### **Changes In The Plan Participation**

- Revocation of participation in the Plan can only occur if you have a change in family status. Please see your Summary Plan Description.

**HEALTH CARE REIMBURSEMENT ACCOUNT CLAIM FORM**

**Plan Year Ending** \_\_\_\_\_

**Employer Information**

**Employer Name:** \_\_\_\_\_

**Employee Information**

First Name                      Middle initial                      Last name                      Social Security Number  
\_\_\_\_\_  
\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Health Care Expenses (Medical, Dental, Vision, Hearing)**

Date Incurred	Provider's Name	Expense for Name, And If Dependent, Relationship	Expenses Description	Reimbursement Requested
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Total Reimbursement Requested: \$** \_\_\_\_\_

**Please Read The Following. Then Sign This Form.**

I certify that all services for which reimbursement is requested under the Plan were incurred by myself or my eligible dependents within the Plan Year of my election, that the expenses associated with these services have been paid by me and that in the case of qualifying health care expenses, they have not been reimbursed or are not reimbursable under any other health care coverage. I will not use qualifying health care expenses reimbursed through my health care reimbursement account as deductions when filing my Federal Income Tax return.

I understand that I am fully responsible for the sufficiency and accuracy of all information relating to health care claims which are provided by me, and that unless an expense is a qualifying expense under the Plan, I may be liable for payment of all related taxes and penalties including interest and penalties for the late payment by the Employer for the Employer's share of Social Security and unemployment taxes on amounts paid from the Plan which relate to such expense.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_