

HEALTH CARE REIMBURSEMENT CLAIM FORM FILING INSTRUCTIONS

Who Can File A Claim

- Only employees participating in the Health Care Flexible Spending Account Plan can file a claim for reimbursement.
- 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 for additional details.

What Expenses Can Be Claimed

- Only expenses for services **INCURRED** during the plan year and associated Grace Period (if applicable) can be claimed for reimbursement.
- Expenses are incurred when you are provided with the Health Care related service that gives rise to the expense and not when you are formally billed or charged for or pay for the expense.
- An expense must be qualifying as defined under Section 213(d) of the Internal Revenue Code. The expense must also be allowed under the employer's Health Care Flexible Spending Account Plan because the Plan may restrict the kind of expenses that may be reimbursed. Review the Plan's Summary Plan Description.
- To assist you in determining whether your expense is qualifying under Section 213(d) of the Internal Revenue Code, access www.avantserve.com:
 - EBIA Health Care Expense Table - Found under the Tools link, this link lists qualifying, potentially qualifying and non-qualifying expenses. You must also review your Summary Plan Description to make sure the expense is also allowed under the Plan.
 - Health Care Spending Account Reimbursement and Documentation Requirements - Found under the Forms and Documents link under documents, this link provides a list of qualifying expenses as well as IRS documentation requirements.

How Do I Complete The Form

- Complete the Employer Information section by listing your employer's name and the Plan Year beginning date and ending date.
- Complete the Employee Information section by listing your name, social security number, address and email address.
- Complete the Health Care expense section by indicating the date of service, the provider's name, the recipient of the expense, the expense type, the relationship of the recipient to the employee, and the amount being requested.

IMPORTANT

- When completing the Health Care expense section, list each claim expense separately on the form
Key Note: You cannot combine expenses that are listed on separate pieces of substantiation. You must make an entry for each piece of substantiation you have for expenses incurred on a given date. For example, if you have 30 prescription receipts, you must enter them as 30 separate claims. Claim forms that have expenses with different substantiation combined together will be returned to you.

Key Note: If more than one eligible expense incurred on the same day is listed on one piece of substantiation, you may enter those expenses as one claim.

- Complete multiple claim forms if the number of expenses that you are seeking reimbursement for is greater than the number of spaces available on the form. Do not simply sign the form and attach a spreadsheet listing all expenses. Forms received in this format will be returned to you.

Key Note: If multiple claim forms are used, make sure that the substantiation for expenses listed on a particular claim form is placed directly behind that claim form.

- Once you have listed all claims, total the amounts and list the total in the Total Reimbursement Requested box.
- Read the Health Care Expense Certification carefully; then sign and date the form.

Substantiation

- Include photocopies of your expense substantiation to this claim form. Please do not staple receipts to the form and please **DO NOT send original receipts.**
- All substantiation must be received in an 8 ½" x 11" format. **If substantiation is not received in this format, your claim form and documentation will be returned to you.**
- Substantiation must contain the following pieces of information:
 - Provider Name
 - Date the service was incurred
 - Recipient of the service
 - Description of service provided
 - Expense amount
- Cancelled checks and credit card statements/receipts are not considered valid substantiation.
- Receipts for OTC expenses that do not clearly identify the product being purchased must be accompanied by a copy of the box or container for each product in which you are requesting reimbursement.



HEALTH CARE REIMBURSEMENT ACCOUNT CLAIM FORM

Employer Information

Employer:	Plan Year:	to
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Employee Information

First Name:	Last Name:	Social Security Number:	-	-
Address:			City:	
State:	Zip Code:	Email Address:		

Health Care Expenses

1	Date of Service:	Provider:	Expense for Name:
	Expense Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Rx <input type="checkbox"/> Orthodontia <input type="checkbox"/> Co-Pay <input type="checkbox"/> OTC <input type="checkbox"/> Parking <input type="checkbox"/> Mileage <input type="checkbox"/> Other: _____	Relationship To Employee: <input type="checkbox"/> Self <input type="checkbox"/> Dependent Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____	Amount Requested:

2	Date of Service:	Provider:	Expense for Name:
	Expense Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Rx <input type="checkbox"/> Orthodontia <input type="checkbox"/> Co-Pay <input type="checkbox"/> OTC <input type="checkbox"/> Parking <input type="checkbox"/> Mileage <input type="checkbox"/> Other: _____	Relationship To Employee: <input type="checkbox"/> Self <input type="checkbox"/> Dependent Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____	Amount Requested:

3	Date of Service:	Provider:	Expense for Name:
	Expense Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Rx <input type="checkbox"/> Orthodontia <input type="checkbox"/> Co-Pay <input type="checkbox"/> OTC <input type="checkbox"/> Parking <input type="checkbox"/> Mileage <input type="checkbox"/> Other: _____	Relationship To Employee: <input type="checkbox"/> Self <input type="checkbox"/> Dependent Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____	Amount Requested:

4	Date of Service:	Provider:	Expense for Name:
	Expense Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Rx <input type="checkbox"/> Orthodontia <input type="checkbox"/> Co-Pay <input type="checkbox"/> OTC <input type="checkbox"/> Parking <input type="checkbox"/> Mileage <input type="checkbox"/> Other: _____	Relationship To Employee: <input type="checkbox"/> Self <input type="checkbox"/> Dependent Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____	Amount Requested:

5	Date of Service:	Provider:	Expense for Name:
	Expense Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Rx <input type="checkbox"/> Orthodontia <input type="checkbox"/> Co-Pay <input type="checkbox"/> OTC <input type="checkbox"/> Parking <input type="checkbox"/> Mileage <input type="checkbox"/> Other: _____	Relationship To Employee: <input type="checkbox"/> Self <input type="checkbox"/> Dependent Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other: _____	Amount Requested:

Total Reimbursement Requested: \$

Health Care Expense Certification

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, and that in the case of qualifying health care expenses, they have not been reimbursed and I will not seek reimbursement 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 that are provided by me, and 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 that relate to such expense.

Signature: _____ **Date:** _____