benefit strategies LLC
SAS 70 Certified

# FLEXIBLE BENEFIT PLAN REIMBURSEMENT REQUEST FORM

FAX CLAIMS TO: (603) 647-4668
CLAIM SUPPORT: (603) 647-4666 or (888) 401-FLEX
EMAIL CLAIM SUPPORT: claimsupport@benstrat.com
MAIL TO: PO Box 1300, Manchester, NH 03105-1300
ONLINE ACCOUNT: http://www.benstrat.com

**Name:** ____________________ **Company:** ____________________
**Home Mailing Address:** **Check if NEW** ☐ **Social Security Number:** ____________________
**Address:** ____________________ **Plan Year:** __________ -to- __________
**City:** __________ **State:** ______ **Zip:** ______ **Telephone:** *Home:* ( ) __________
**E-mail:** ____________________ *Daytime Phone:* ( ) __________

## INSTRUCTIONS / REMINDERS

1. Be sure to attach a **COPY** of the <u>itemized receipt</u>(s), or if you have insurance, please send the <u>Explanation of Benefits Statement</u>. **KEEP** original receipts for your tax records.
2. **<u>Complete</u>** claims received by NOON on Thursday will be generally processed on Friday.
3. The **participant** must **sign** claim form.
4. Incomplete or unsigned forms will be **returned** to the participant and **not** processed
5. Reimbursement requests should be for a minimum of **<u>$25</u>** (unless using remaining account balance)

Health Care Reimbursement Account documentation may include statements, itemized bills, and/or insurance “Explanation of Benefits” forms. Documentation must show:

1. The date the expense was **<u>incurred</u>** (not the date paid).
2. The provider of services.
3. A description of the service and/or expense.
4. The amount of the expense for which you are responsible.
5. *Note*: Cancelled checks, credit card receipts, and balance forward statements are <u>NOT</u> acceptable documentation

## PARTICIPANT STATEMENT & SIGNATURE (Required)

**To the best of my knowledge and belief,** my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for IRS eligible expenses incurred by my ***<u>legal</u>*** dependents or myself (Domestic/Civil Union Partners are <u>not</u> IRS eligible dependents in most cases). I certify that these expenses have not been and will not be reimbursed from any other source and will not be claimed as an income tax deduction.

**PARTICIPANT SIGNATURE** (REQUIRED) ______________________________ **Date:** __________

## HEALTH CARE EXPENSES REQUESTING REIMBURSEMENT Use second sheet if needed

| Amount to be Reimbursed | Service Date(s) | Description | Person receiving product / service |
|---|---|---|---|
| $ | | ☐ Medical ☐ Dental/Ortho ☐ Over-the-counter items<br>☐ Vision ☐ Prescription ☐ ____________ | |
| $ | | ☐ Medical ☐ Dental/Ortho ☐ Over-the-counter items<br>☐ Vision ☐ Prescription ☐ ____________ | |
| $ | | ☐ Medical ☐ Dental/Ortho ☐ Over-the-counter items<br>☐ Vision ☐ Prescription ☐ ____________ | |
| $ | | ☐ Medical ☐ Dental/Ortho ☐ Over-the-counter items<br>☐ Vision ☐ Prescription ☐ ____________ | |

**$__________TOTAL Health Care Reimbursement Requested** include second page total (Payments are made directly to the employee.)

## DEPENDENT CARE EXPENSES REQUESTING REIMBURSEMENT

| Amount to be Reimbursed | Service Date(s) | Description | Person receiving service |
|---|---|---|---|
| $ | | | |
| $ | | | |
| $ | | | |

**$__________TOTAL Dependent Care Assistance Requested** (Payments are made directly to the employee.)

Please attach receipts **or** have your provider complete the **Dependent Care Provider Certification** below.

**<u>Dependent Care Provider Certification:</u>** I certify that I have provided and been paid for the services above.

**Provider’s Name:** ____________________ **Provider’s Signature** ____________________

## List …..EXPENSES REQUESTING REIMBURSEMENT

***Note*: Cancelled checks, credit card receipts, and balance forward statements are <u>NOT</u> acceptable documentation.**

| **Amount to be Reimbursed** | **Service Date(s)** | **Description** | **Person receiving product / service** |
|---|---|---|---|
| $ | | ☐ Medical ☐ Dental/Ortho ☐ Over-the-counter items<br>☐ Vision ☐ Prescription ☐ ____________________ | |
| $ | | ☐ Medical ☐ Dental/Ortho ☐ Over-the-counter items<br>☐ Vision ☐ Prescription ☐ ____________________ | |
| $ | | ☐ Medical ☐ Dental/Ortho ☐ Over-the-counter items<br>☐ Vision ☐ Prescription ☐ ____________________ | |
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| $ | | ☐ Medical ☐ Dental/Ortho ☐ Over-the-counter items<br>☐ Vision ☐ Prescription ☐ ____________________ | |
| $ | | ☐ Medical ☐ Dental/Ortho ☐ Over-the-counter items<br>☐ Vision ☐ Prescription ☐ ____________________ | |
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| $ | | ☐ Medical ☐ Dental/Ortho ☐ Over-the-counter items<br>☐ Vision ☐ Prescription ☐ ____________________ | |

**$ ________________________ Total Second Page Requested** Please enter on the front page (Payments are made directly to the employee.)