REQUEST FOR REIMBURSEMENT

Health Care Reimbursement Account
Dependent Care Reimbursement Account

PO Box 1300, Manchester, NH 03105-1300 TEL: (603) 647-4666
Web Site: www.benstrat.com **FAX: (603) 647-4668**

1	EMPLOYEE INFORMATION				
Name:				SSN:	
Home Mailing Address:				Company:	
☐ Check if NEW address	city	state	zip	Plan Year:	

You may make copies of this form or obtain copies at our website, www.benstrat.com , under available forms.

2 REIMBURSEMENT REQUEST INSTRUCTIONS (Important –Read Carefully!)

1) Claim form must be filled out COMPLETELY and signed. Medical expenses must FIRST be submitted to your insurance provider. Only out-of-pocket expenses incurred during your active participation in the plan year are reimbursable. (Incomplete forms **will be** returned.)

   Mail or FAX form and documentation, ***5 Page Limit for FAXES***, to Benefit Strategies at the above address or FAX. #

2) Complete claims received by NOON on Thursday will be processed for reimbursement on Friday. **Does not apply to all clients.*

   A. COPIES of all third party documentation for expenses you are claiming should be submitted on **8 1/2 by 11 paper** ***along with*** your COMPLETED Reimbursement Request. *Please keep original receipts for your tax records.*

   B. Documentation must show: the date the expense was **incurred** (not the date paid), the amount of the expense that you are responsible for, the provider of services, and a description of the service and/or expense.

   C. Health Care Reimbursement Account documentation can include statements, itemized bills, and/or insurance "Explanation of Benefit" forms. Canceled checks, credit card receipts, and balance forward statements are not acceptable documentation.

3) Dependent Care Reimbursement Account documentation must show the dates of service, provider's name, and dependent's name. Section 4 of this form may be used as eligible documentation. (You must have on file the Taxpayer ID Number or Social Security Number of your Dependent Care providers. You will need to provide these numbers to the IRS when filing your taxes.)

3 EXPENSES REQUESTING REIMBURSEMENT *(Use additional sheets as necessary)*

Amount to be Reimbursed:	Type of Service: Medical, Dental, Vision, Dependent Care	Date Service was Incurred: (not payment date)	Description of Service: Include name and relationship of person for whom services were provided. For Dependent Care, list provider's name.
$			
$			
$			
$			
$			

(Payments are made directly to the employee. They cannot be assigned to the providers of service.)

$_____**TOTAL Reimbursement Requested**

4 CHILD / DEPENDENT CARE PROVIDER RECEIPT: (May be used in lieu of other child care documentation)

Provider's Name: _____ Provider's Address: _____

I certify that I have provided the services as listed in section 3 above, and that I have been paid for those services.

X _____

Provider's Signature **Date**

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 eligible expenses incurred by my legal dependents or myself. 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.

EMPLOYEE SIGNATURE (Required)_____**Date**_____

REV. 6/15/04