

# REIMBURSEMENT CLAIM FORM

## PART 1

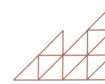
EMPLOYEE NAME	SOCIAL SECURITY NUMBER	EMPLOYER
If this is your first claim, or if address has changed, please fill in your address		
STREET ADDRESS or P.O. BOX NUMBER	CITY	STATE ZIP CODE

## PART 2

PROVIDER of SERVICE / ITEM	SERVICE RENDERED / ITEM PURCHASED	DATE of SERVICE	EXPENSE TYPE	AMOUNT	
			MED DEP		FOR OFFICE USE ONLY
			MED DEP		
			MED DEP		
			MED DEP		
			MED DEP		
			MED DEP		
<b>TOTAL</b> ↘					

### EMPLOYEE CERTIFICATION

I request reimbursement for my dependent care and/or medical care as itemized above. Enclosed are EOB's, bills and receipts verifying these expenses. These expenses are not eligible for reimbursement from any other source. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code and that they cannot be claimed as credits or deductions on my personal income tax.



**Benefit Resource, Inc.**  
 2320 Brighton-Henrietta Townline Rd.  
 Rochester, New York 14623-2782  
 ATTN: Claims Department

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Cut along dotted line)

### PLEASE FOLLOW THESE INSTRUCTIONS WHEN SUBMITTING YOUR CLAIM:

- Part 1 of the claim form must include the employee name, social security number and name of employer. Fill in the address *only* if this is your first claim or your address has changed.
- Part 2 of the claim form must be completed in full.
- The claim form *must* be signed and dated after reading the employee certification.
- For each item you are claiming, attach a copy of bills, statements, or insurance company Explanation of Benefits (EOB's). Retain originals for your personal tax records. The statement of expense from your provider *must* include the following information:
  - Then name of the provider;
  - The type of service provided;
  - The date(s) the service was provided;
  - Your out-of-pocket cost for the service;
  - The name of the person receiving the service.
- Submit the completed claim form and related documentation to:

**Benefit Resource, Inc.**  
 2320 Brighton-Henrietta Townline Rd.  
 Rochester, New York 14623-2782  
 ATTN: Claims Department

### REIMBURSABLE MEDICAL SPENDING ACCOUNT EXPENSES (MED)

Following are examples of services and supplies that may be reimbursed from your Medical Spending Account. In general, eligible expenses include those that are not *fully* covered by a health care plan and are prescribed by a doctor or other licensed professional for treatment of a specific disease or medical condition.

Acupuncture	Infertility treatments	Psychologist fees
Ambulance	Insulin	Radical Keratotomy
Birth control pills	Laboratory fees	Routine physicals, other non-diagnostic services
Braille-books and magazines	Nurses' fees	Special education for the blind
Car controls for the handicapped	Obstetrical expenses	Surgery
Chiropractors	Orthodontics	Telephones for the deaf
Contact lenses and solutions	Oxygen	Television audio display equipment for the deaf
Co-pay amounts	Pap smears	Therapeutic care for drug and alcohol addiction
Crutches	Prescription drugs and medical supplies*	Transportation expenses for doctor visits
Dental fees	Prescription eyeglasses and examination fees	Vaccinations
Handicapped person's cost for special schools and homes	Physical therapy	Vitamins by prescription
Hearing device and batteries	Physician fees	Well baby care
Hospital bills	Psychiatric care	X-rays

\* Over-the-counter medications and supplies are generally not reimbursable.

### REIMBURSABLE DEPENDENT CARE SPENDING ACCOUNT EXPENSES (DCA)

You can use your Dependent Care Spending Account to pay for DAY CARE expenses which meet ALL of the following requirements:

- The service must be for the care of a child less than 13 years old whom you can claim as a dependent on your federal income tax return, or for a spouse or other dependent who is not capable of self-care;
- The service must be for the care of a dependent described above, or for household services;
- If the expenses are for services which are provided outside of your home, they must be for the care of a dependent who is less than 13 years old or who regularly spend at least 8 hours per day in your home;
- The service must enable both you and your spouse to be gainfully employed or attend school full-time; and
- You must report your provider's name, address, and taxpayer identification number on your federal tax return.

There are additional requirements which apply to the **provider** of the care; the provider must meet **ALL** of these requirements in order for the amounts paid to the provider to be reimbursable:

- The provider cannot be your child if he or she is less than 19 years old at the close of the taxable year;
- The provider cannot be someone whom you (or your spouse) claim as a dependent on your federal tax return; and
- If the provider is a dependent care center which regularly provides care for more than six people, the center must comply with applicable state and local laws and regulations.

