



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:** UMASS President's Office
Home Mailing Address: _____ **Check if NEW** **Social Security Number:** _____
Address: _____ **Plan Year:** _____ **-to-** _____
City: _____ **State:** _____ **Zip:** _____ **Telephone: Home:** () _____
E-mail: _____ **Daytime Phone:** () _____

INSTRUCTIONS / REMINDERS

- | | |
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| <ol style="list-style-type: none"> 1. Be sure to attach a COPY of the <u>itemized receipt(s)</u>, or if you have insurance, please send the <u>Explanation of Benefits Statement</u>. KEEP original receipts for your tax records. 2. Complete 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 \$25 (unless using remaining account balance) | <p>Health Care Reimbursement Account documentation may include statements, itemized bills, and/or insurance "Explanation of Benefits" forms. Documentation must show:</p> <ol style="list-style-type: none"> 1. The date the expense was incurred (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. <i>Note:</i> Cancelled checks, credit card receipts, and balance forward statements are NOT acceptable documentation |
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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 legal dependents or myself (Domestic/Civil Union Partners are not 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
\$		<input type="checkbox"/> Medical <input type="checkbox"/> Dental/Ortho <input type="checkbox"/> Over-the-counter items <input type="checkbox"/> Vision <input type="checkbox"/> Prescription <input type="checkbox"/> _____	
\$		<input type="checkbox"/> Medical <input type="checkbox"/> Dental/Ortho <input type="checkbox"/> Over-the-counter items <input type="checkbox"/> Vision <input type="checkbox"/> Prescription <input type="checkbox"/> _____	
\$		<input type="checkbox"/> Medical <input type="checkbox"/> Dental/Ortho <input type="checkbox"/> Over-the-counter items <input type="checkbox"/> Vision <input type="checkbox"/> Prescription <input type="checkbox"/> _____	
\$		<input type="checkbox"/> Medical <input type="checkbox"/> Dental/Ortho <input type="checkbox"/> Over-the-counter items <input type="checkbox"/> Vision <input type="checkbox"/> Prescription <input type="checkbox"/> _____	

\$ _____ **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.

Dependent Care Provider Certification: I certify that I have provided and been paid for the services above.

Provider's Name: _____ Provider's Signature _____

ListEXPENSES REQUESTING REIMBURSEMENT

Note: Cancelled checks, credit card receipts, and balance forward statements are NOT acceptable documentation.

Amount to be Reimbursed	Service Date(s)	Description			Person receiving product / service
\$		<input type="checkbox"/> Medical	<input type="checkbox"/> Dental/Ortho	<input type="checkbox"/> Over-the-counter items	
		<input type="checkbox"/> Vision	<input type="checkbox"/> Prescription	<input type="checkbox"/> _____	
\$		<input type="checkbox"/> Medical	<input type="checkbox"/> Dental/Ortho	<input type="checkbox"/> Over-the-counter items	
		<input type="checkbox"/> Vision	<input type="checkbox"/> Prescription	<input type="checkbox"/> _____	
\$		<input type="checkbox"/> Medical	<input type="checkbox"/> Dental/Ortho	<input type="checkbox"/> Over-the-counter items	
		<input type="checkbox"/> Vision	<input type="checkbox"/> Prescription	<input type="checkbox"/> _____	
\$		<input type="checkbox"/> Medical	<input type="checkbox"/> Dental/Ortho	<input type="checkbox"/> Over-the-counter items	
		<input type="checkbox"/> Vision	<input type="checkbox"/> Prescription	<input type="checkbox"/> _____	
\$		<input type="checkbox"/> Medical	<input type="checkbox"/> Dental/Ortho	<input type="checkbox"/> Over-the-counter items	
		<input type="checkbox"/> Vision	<input type="checkbox"/> Prescription	<input type="checkbox"/> _____	
\$		<input type="checkbox"/> Medical	<input type="checkbox"/> Dental/Ortho	<input type="checkbox"/> Over-the-counter items	
		<input type="checkbox"/> Vision	<input type="checkbox"/> Prescription	<input type="checkbox"/> _____	
\$		<input type="checkbox"/> Medical	<input type="checkbox"/> Dental/Ortho	<input type="checkbox"/> Over-the-counter items	
		<input type="checkbox"/> Vision	<input type="checkbox"/> Prescription	<input type="checkbox"/> _____	
\$		<input type="checkbox"/> Medical	<input type="checkbox"/> Dental/Ortho	<input type="checkbox"/> Over-the-counter items	
		<input type="checkbox"/> Vision	<input type="checkbox"/> Prescription	<input type="checkbox"/> _____	
\$		<input type="checkbox"/> Medical	<input type="checkbox"/> Dental/Ortho	<input type="checkbox"/> Over-the-counter items	
		<input type="checkbox"/> Vision	<input type="checkbox"/> Prescription	<input type="checkbox"/> _____	
\$		<input type="checkbox"/> Medical	<input type="checkbox"/> Dental/Ortho	<input type="checkbox"/> Over-the-counter items	
		<input type="checkbox"/> Vision	<input type="checkbox"/> Prescription	<input type="checkbox"/> _____	
\$		<input type="checkbox"/> Medical	<input type="checkbox"/> Dental/Ortho	<input type="checkbox"/> Over-the-counter items	
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\$		<input type="checkbox"/> Medical	<input type="checkbox"/> Dental/Ortho	<input type="checkbox"/> Over-the-counter items	
		<input type="checkbox"/> Vision	<input type="checkbox"/> Prescription	<input type="checkbox"/> _____	
\$		<input type="checkbox"/> Medical	<input type="checkbox"/> Dental/Ortho	<input type="checkbox"/> Over-the-counter items	
		<input type="checkbox"/> Vision	<input type="checkbox"/> Prescription	<input type="checkbox"/> _____	

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