REQUEST FOR REIMBURSEMENT FORM
HEALTH CARE

EMPLOYER______________________________

Please print or type

Employee (Last Name, First Name, Middle Init.)

Email Address

Address ❒ Check if this is a new address

City State Zip

Daytime Phone

❑ Check here if address change

Please be sure to staple documentation of services provided to the back of this claim form. Acceptable documentation is: 1) Explanation of Benefits (EOB) from the insurance company; 2) statement or bill from the health care provider that shows date of service and your financial responsibility; or 3) for contact lens supplies and co-payments only, a receipt.

To be eligible for reimbursement, a health care expense must be for you, your legal spouse, or dependent as defined by the IRS. Furthermore, the expense must be for services performed during the plan year; and not be covered by any other health insurance (i.e. an out-of-pocket expense).

INSTRUCTIONS

Fill in the information below for health care expenses incurred by you or your eligible dependent. Each expense item must be accompanied by a receipt or bill or copy of your receipt or bill stating the DATE OF SERVICE. *Do not attach receipts or bills, which do not identify your expense as a health care expense.* NOTE: Expenses covered under a medical, dental, vision or hearing plan must be submitted under that plan first. **ATTACH A COPY OF THE EXPLANATION OF BENEFITS YOU RECEIVED FROM THE INSURER OR A CO-PAY RECEIPT.** Please keep a copy for your records.

Date Expense Incurred	Name & Relationship of Person Incurring Expense	Description of Service/Expense	Name of Service Provider	Your Unreimbursed Expense
				$
			TOTAL Medical Care Expense Claim:	**$**

CERTIFICATION BY THE PLAN PARTICIPANT

I certify that I am responsible for the validity of this claim and that the expenses listed are not eligible for further reimbursement under any other health plan. I further certify that I have not and will not claim the listed expenses as an income tax deduction.

Signature of Participant ______________________________ Date____________

SEND COMPLETED CLAIM FORM AND RECEIPTS TO:

Email to Flexcs@baclink.com

Benefit Administration Company
P.O. Box 550
Seattle, WA 98111-0550
(206) 625-1800 or (800) 967-3709 ext. 307

OR, FAX CLAIM FORM TO:
(Note: If faxing claim **do not** mail original.)

(206) 682-8016 (FAX)

PLEASE KEEP A COPY OF ALL SUBMITTED CLAIMS AND DOCUMENTATION. A FEE MAY BE CHARGED FOR REQUESTED COPIES.

Healthcare and Dependent Day Care Claim Form Instructions Bulletin

REQUEST FOR REIMBURSEMENT

Prompt claim processing is largely dependent on the submittal of a properly completed *Request for Reimbursement* form (Health Care - vs. - Dependent Day Care Reimbursement). A properly completed form includes:

- Legible personal information (employee name & current address)
- Employer Name (when not using a pre-printed form from your Employer)
- A marked change of address box, if applicable
- Legible claim description and expense information
- A legible, itemized statement and/or receipts from your provider
- An Explanation of Benefits (EOB) from all health insurance carriers
- Claim total
- Employee SIGNATURE
- A separate claim form for each plan year

CLAIM PROCESSING TIMELINES

Properly completed Request for Reimbursement forms received 72 hours before your plans' scheduled check-printing date will be processed in that check run. If you submit your claim request via facsimile, the deadline is 1:00 p.m. before the 72-hour cutoff. For example, if your plans' check printing date is Friday, the check run will include all forms received by 1:00 p.m. on Tuesday. If your Request for Reimbursement is incomplete, it's processing may be delayed until the matter is resolved.

Please retain a copy of your Request for Reimbursement Form, along with all supporting documentation for your itemized expenses.

CHECK STOP PAYMENT AND/OR CHECK REISSUE REQUESTS

Benefit Administration Company (BAC) will process check stop payment and/or reissue according to the following guidelines:

- All stop payment requests will be held for a minimum waiting period of ten business days from the original check release date.
- Once BAC has placed the stop payment with the financial institution, the reissued check will be held for 2 business days in accordance with the financial institution's requirement.
- **A $30 processing fee will apply for all stop payment/reissued checks not resulting from a BAC error**
- BAC will issue a replacement check for a damaged original check only after the original check has been returned to BAC

OTHER HELPFUL HINTS

- Eligible expenses are determined by the date of service, NOT the date the payment is made to the provider. Therefore, cancelled checks, bank statements, credit card receipts and provider balance forward statements are not acceptable documentation.
- A Dependent Care claim may be submitted up to 3 months in advance of services rendered
- Once the plan year has begun, you may only change your elected annual contribution amount if you have a change in family status (see your Summary Plan Description for more details).
- IRS rules require that the balance remaining in your reimbursement account (healthcare and/or dependent care) be forfeited at the end of the plan year.

EXAMPLES OF EXPENSES NOT ELIGIBLE FOR REIMBURSEMENT

- Health Care Spending Account: weight loss programs unless prescribed to treat a specific medical condition, cosmetic surgery, teeth bleaching, missed appointment or late payment fees or custodial care (nursing home)
- Dependent Care Spending Account: overnight camp, diapers and care provided while you or your spouse are not working