


**REIMBURSEMENT CLAIM FORM (Please Print Clearly)**

*Check here if new address or 1st claim submission*

PART 1		PART 2: Complete if this is your 1 <sup>st</sup> claim or your address has changed		
Employee Name:		Street or P.O. Box:		
Member ID (typically your SSN):		City:		
Employer:		State:	Zip Code:	
PART 3				
*Pay from Prior PY	Provider & Service Rendered/Item Purchased	Date(s) of Service	Amount	For Office Use Only
<input type="checkbox"/> YES				
<input type="checkbox"/> YES				
<input type="checkbox"/> YES				
<input type="checkbox"/> YES				
<input type="checkbox"/> YES				
<input type="checkbox"/> YES				
<input type="checkbox"/> YES				
<input type="checkbox"/> YES				
<input type="checkbox"/> YES				
<input type="checkbox"/> YES				
<input type="checkbox"/> YES				
<input type="checkbox"/> YES				
<input type="checkbox"/> YES				
<input type="checkbox"/> YES				
<b>Employee Certification:</b> I request reimbursement for Medical and/or Dependent Care expenses as indicated above. Enclosed are itemized bills, receipts or EOB's verifying these expenses. Each expense listed is for a service/item provided to me, my spouse or an eligible dependent, has not been purchased with a Beniversal™ card, and will not be reimbursed from any other source. Medical expenses were incurred only for an immediate medical purpose. 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.				<b>← TOTAL</b>
<b>Signature:</b>		<b>Date:</b>		<b>ATTN: Claims Department</b> <b>Benefit Resource, Inc.</b> <b>2320 Brighton-Henrietta TL Rd.</b> <b>Rochester, NY 14623</b> <b>Fax: (585) 427-9320</b> 

*\*If your Plan offers the extended grace period allowed by IRS regulations, you must check Yes if you wish to have this expense reimbursed from the prior Plan Year.*

**INSTRUCTIONS FOR SUBMITTING YOUR CLAIM:**

- Part 1 of the claim form *must* be completed in full.
- Part 2 of the claim form should only be completed if this is your first claim or your address has changed.
- Part 3 of the claim form *must* be completed in full.
- For each item you are claiming in Part 3, you must attach a copy of itemized bills, statements, receipts or insurance company Explanation of Benefits (EOB's). This documentation from your provider *must* include the following information (*please retain originals for your personal records*).
  - Name of provider
  - Date(s) service was provided
  - Type of service provided (for prescriptions, must include name of drug)
  - Your out-of-pocket cost for the service
  - Name of person receiving the service
- IRS regulations may require additional documentation for certain expenses (e.g. for dual purpose items).
- The claim form *must* be signed and dated after reading the Employee Certification.
- Submit the completed claim form and related documentation to:

**ATTN: Claims Department**  
**Benefit Resource, Inc.**  
**2320 Brighton-Henrietta TL Rd.**  
**Rochester, NY 14623-2782**  
**Fax: (585) 427-9320**

**CLAIM SUBMISSION REMINDERS:**

- Credit card statements, cancelled checks and balance forward/prior balance statements *are not* acceptable.
- The service being claimed must be provided within your Plan Year to you, your spouse or your dependent.
- In general, IRS regulations do not require that you pay for a service before requesting reimbursement. A request for reimbursement must be based on the date when the service was provided, not the date when a payment was made. (The IRS allows one exception: orthodontia expenses can be based on date of payment, date of service or payment due date on statements/coupons.)
- Claims must be submitted *after* a service is provided, but *before* the end of the run-out period following the end of your Plan Year.
- Claims must be received by Benefit Resource, Inc. within the time frames specified in the Plan Highlights.
- The expense being claimed cannot be reimbursed from any other source.

**SOME EXPENSES THAT ARE NOT ELIGIBLE FOR REIMBURSEMENT FROM A MEDICAL REIMBURSEMENT ACCOUNT INCLUDE:**

- General health expenses (e.g. vitamins, nutritional or dietary supplements).
- Cosmetic services, exercise programs, weight loss programs (unless substantiated by a physician as preventing, treating or mitigating a specific physical defect or illness).
- Personal care items (e.g. shampoo, soap, electric toothbrush, toothpaste, mouthwash).
- Non-prescription sunglasses (unless substantiated by a physician as preventing, treating or mitigating a physical defect or illness).
- Bleaching of teeth.
- Health club dues.
- Insurance premiums.



Phone: 1-800-473-9595  
 Website: [www.BenefitResource.com](http://www.BenefitResource.com)