Aviben

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Claim Reimbursement Form

Name: _____ **Phone:** _____ **SSN:** _____ last 4 digits only

Address: _____ **Employer:** _____

Health Out-of Pocket Costs (Health Reimbursement Arrangements or Flexible Spending Accounts)									
Service Provided By	**Date Incurred**	**Office Visit**	**RX**	**Dental**	**Vision**	**OTC Drugs**	**Other, please specify**	**$ Amount Incurred**	**Plan Type (HRA/FSA)**
		○	○	○	○	○			
		○	○	○	○	○			
		○	○	○	○	○			
		○	○	○	○	○			
ATTACH RECEIPTS							**Total Health Care Expense Claim**		

Note: Reimbursements will be paid out of your FSA before your HRA unless we are unable to pay out of your FSA for eligibility reasons or are directed to reimburse differently.

Dependent Care Reimbursement Claim			
Name and Age of Dependent(s)	**Date(s) Incurred**	**Name of Provider / Tax ID or SSN**	**$ Amount Incurred**
ATTACH CARE PROVIDER RECEIPT		**Total Dependent Care Expense Claim**	

Health & Excepted Benefit Premium Costs (attach copy of your current insurance premium invoice—must be verified annually.)					
Insurance	**Premium Amount/Monthly**	**Months Paid**	**Automatic Monthly Reimbursements**	**Total $**	**Plan Type (HRA / 125 EB)**
Medical (HRA Only)					
Dental					
Vision					
AD&D					
Hospitalization					
Cancer					
Other:					

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Comments or special instructions

- I certify that all expenses for which reimbursement is claimed by submission of this form were incurred by me or my spouse, or dependent(s).
- I certify that the medical expenses incurred by me or my dependents are qualifying expenses as defined by the Internal Revenue Service Code. If these expenses are not qualified expenses, I understand that I will be liable for payment of all related taxes on all ineligible amounts paid out by the Plan.
- I certify that the health expenses claimed have not been reimbursed or cannot be reimbursed under any other health plan coverage.
- I take full responsibility for the accuracy and veracity of all the information I have provided and release Educators Benefit Consultants, LLC from all liability.
- By signing and/or submitting this electronically, I agree that electronic signatures are valid and enforceable and that no certification authority or other third party verification is necessary to validate my electronic signature.
- **PLEASE NOTE**: The IRS does not allow you to contribute to an HSA and take reimbursements from your HRA in the same tax year. However, if your HRA is a post-employment HRA you can make contributions to an HSA until employment termination. Additionally, if you have a Premium Only HRA plan, you can be reimbursed for non-subsidized insurance premiums if your plan allows.
- **PLEASE NOTE**: The IRS does not allow reimbursements from an HRA for insurance premiums that are tax subsidized or paid for with pre-tax dollars.
- **FOR SECTION 125 FLEXIBLE BENEFIT PLANS**: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or will not be presented for reimbursement through any other health coverage plan. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense. I declare that the information I have furnished above is, to the best of my knowledge and belief, true, correct and complete.

Signature _____ Date _____