MEDICAL AND DEPENDENT CARE REIMBURSEMENT CLAIM FORM

TO USE THE CLAIMS FAX SERVICE PLEASE FAX or email YOUR CLAIM TO:
1-866-857-9421
shawn@beneflexhawaii.com

PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS FORM BEFORE FILLING YOUR CLAIM. PLEASE PRINT LEGIBLY OR TYPE THE REQUIRED INFORMATION. IF YOU HAVE QUESTIONS CALL 254-9166. ADDITIONAL CLAIM FORMS CAN BE DOWNLOADED FROM www.beneflexhawaii.com

EMPLOYEE INFORMATION

EMPLOYEE NAME:	LAST 4 OF SSN:	CHECK HERE IF THIS IS A NEW ADDRESS ☐
MAILING ADDRESS: (INCLUDING CITY, STATE, ZIP)		
EMPLOYER'S NAME:	TOTAL # OF PAGES:	
EMAIL ADDRESS:	PHONE NUMBER:	

EXPENSES TO BE REIMBURSED

MEDICAL REIMBURSEMENT ACCOUNT

	NAME & RELATIONSHIP TO EMPLOYEE IF DEPENDENT RECEIVED SERVICES:	DATE SERVICES INCURRED:	TOTAL FOR EACH LINE:
TOTAL MEDICAL: DR. APT & OTHER			$
TOTAL DENTAL EXPENSES:			$
TOTAL PRESCRIPTIONS:			$
TOTAL OTHER & **OTC (RX Required Effective 1/1/2011)** ITEMS:			$
Attach Copies of Receipts Supporting Each Item of Expense		**TOTAL (Minimum $25.00*)**	$

DEPENDENT CARE REIMBURSEMENT ACCOUNT

NAME OF DEPENDENT CARE PROVIDER	FEDERAL ID # OR SOCIAL SECURITY # OF CARE PROVIDER	NAME & RELATIONSHIP OF DEPENDENT	AGE OF DEP.	DATES OF SERVICE		AMOUNT OF CLAIM
				FROM (MO/DAY/YR)	TO (MO/DAY/YR)	
						$
						$
						$
						$
Attach Copies of Receipts Supporting Each Listed Item					**TOTAL**	$

EMPLOYEE STATEMENT – READ CAREFULLY

The undersigned ***Bene-Flex*** participant certifies that I have incurred the expenses listed above within the current plan year, in the amount shown and qualify for reimbursement under the provisions of my employer's health/dental plan, inclusive of deductible and coinsurance amounts and not including any amounts which will be reimbursed to me by any medical insurance plan. IRS regards the date incurred as being when the service is rendered, not when you actually pay the bill. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and validity of all information relating to this claim that is provided by the undersigned. The undersigned further understands that since these expenses are reimbursed by our plan administrator they may not be claimed on my income tax filling at the end of this tax year. If sending by fax I acknowledge that the copy of the signature below is authentic.

EMPLOYEE SIGNATURE	DATE

RETAIN THE ORIGINAL RECEIPT(S) AND A COPY OF THIS FORM FOR YOUR RECORDS FOR 3 YRS.–**SEPARATE FORMS MUST BE USED FOR DIFFERENT PLAN YEARS**.

All requested information on this claim form, including your name, last 4 of SSN, signature and date, must be provided. Failure to do so will result in a return of your claim.

WHEN FAXING A CLAIM PLEASE DO NOT FAX THIS PAGE, IT IS INFORMATIONAL & FOR YOUR RECORDS ONLY. ALSO NO COVER SHEET IS NEEDED, SIMPLY FAX STARTING WITH THE CLAIM FORM AS YOUR FIRST PAGE. TO HELP US CONSERVE PAPER PLS CONSOLIDATE YOUR ITEMS/EXP ON LIMITED NUMBER OF PAGES.

Requirements for Filling a Medical Reimbursement Claim

- To request reimbursement, please provide a copy of each item you are seeking reimbursement along with a copy of page 1 of this form. Copies can be statements, bills, or receipt from your service provider(s) with their name, address and phone number, also showing the services received & date incurred. All supporting documentation must clearly identify the service provided, date on which the services were provided (**not date you paid for it**), and the amount of the expense and your insurance participation. Claims can be made for those family members that appear on your income tax return. Please send legible copies; your original statements, bills, or receipts and copy of the claim form should be retained by you.
- Copies of cancelled checks or charge card receipts will not be accepted as the sole substantiation of documenting expenses incurred.
- **Services must have been incurred to receive reimbursement. You may not request reimbursement until you have received the service, regardless of when you pay for it, therefore treatment plans are not eligible for reimbursement.**
- Reimbursement can only be made for expenses resulting from services that have been provided within your plan year and when your claims reach a minimum of $25.00.
- According to the IRS regulations, any unused year-end balance in your spending account(s) may be carried over to the next plan year only if you employer has amended your plan for the $500.00 rollover or elected the 75 day Extension of time to incur, Please check your HR.
- ***Requests for reimbursement must total at least $25.00, except at the end of the plan year when your balance is already less than $25.00, at which time the request may be for less than $25. If your balance is greater than $25.00 & your claim totals less than $25.00 will be returned to you unless you mark the claim "FINAL CLAIM FOR PLAN YEAR".**
- You have 90 days following the end of the plan year to submit claims for reimbursement for services incurred during the prior plan year. Reimbursement claims not postmarked by the 90th day will be rejected. **Corrections to claims received after the 90th day will not be accepted. To insure that your claim is processed, please include all required receipts and postmark it prior to the 90th day.**

Requirements & Additional Information for Filling a Dependent Care Reimbursement Claim

- According to the IRS regulations, dependent care reimbursement claims cannot be processed without receipts signed by the provider showing the name, address, beginning and ending dates of service, and the amount of expense. **You must provide the tax I.D. (or social security) number of the provider(s) on this claim form or the receipt.**
- **The IRS requires that you incur and complete the service period of your dependent care expenses before you can be reimbursed.**
- The maximum amount of your claim for dependent care expenses is equal to the amount currently in your Dependent Care spending account. Therefore funds cannot be advanced.
- Under a Dependent Care Reimbursement Account a qualified dependent is your dependent under age 12 or your dependent or spouse who is physically or mentally incapable of self-care. According to the IRS, physical or mental incapacity is not being able to dress, clean, or feed oneself.
- Payments for dependent care cannot be made to you, your spouse or anyone you claim as a dependent. If the person you make payments to is your child, he or she must be age 19 or older.
- Dependent care expenses while you are on leave from work (sick, vacation, etc.) or during periods of no work are not considered eligible expenses. Dependent care expenses are eligible to employees that both you and your spouse work full time or your spouse is a full time student.
- The maximum reimbursement is $5,000, if you are married filling a joint return, single or divorced. If you are married filling separate returns the maximum is $2,500.

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Please fax or email your completed reimbursement form and the attachments to:

Fax #: 1-866-857-9421

Email address: shawn@beneflexhawaii.com

or it can be mailed to P.O. Box 428, Kailua, HI 96734

Please download additional claim forms from:

www.beneflexhawaii.com