Health Reimbursement Arrangement Request Form

benefit strategies LLC

FAX: (603) 647-4668 (Max of 15 pages)
Address: PO Box 1300, Manchester, NH 03105-1300
E-Mail: Flexdept@benstrat.com

Employee Name: (First, Last) ____________________ Last 4 digits of SSN: ☐☐☐☐

Primary Phone: ____________________ Employer: ____________________

Email: ____________________

E-mail is required to receive important account notifications.

Fill out form completely, including signature, and fax or mail to Benefit Strategies at the address listed above. Incomplete and unsigned claims will be returned. Please limit the number of pages faxed to a maximum of 15 pages. Reimbursement requests should be for a minimum of $25 (unless using remaining account balance). Notifications will be sent via e-mail for claim confirmation, payment notification and denial letters. Claims will be applied to the earliest eligible plan year. **Please Note: Legislation recently enacted a law that mandates some OTC expenses will no longer be eligible for reimbursement under health FSA effective January 1, 2011.**

HEALTH REIMBURSEMENT ARRANGEMENT EXPENSES

Amount to be Reimbursed	Service Date(s)	Description (Not all plans allow all descriptions below, please refer to your plan description for the details of your plan)	Person receiving product / service
$		☐ Deductible ☐ Inpatient Services ☐ Medical ☐ Coinsurance ☐ Outpatient Services ☐ Prescription ☐ Other (please describe): ____________	
$		☐ Deductible ☐ Inpatient Services ☐ Medical ☐ Coinsurance ☐ Outpatient Services ☐ Prescription ☐ Other (please describe): ____________	
$		☐ Deductible ☐ Inpatient Services ☐ Medical ☐ Coinsurance ☐ Outpatient Services ☐ Prescription ☐ Other (please describe): ____________	
$		☐ Deductible ☐ Inpatient Services ☐ Medical ☐ Coinsurance ☐ Outpatient Services ☐ Prescription ☐ Other (please describe): ____________	
$		☐ Deductible ☐ Inpatient Services ☐ Medical ☐ Coinsurance ☐ Outpatient Services ☐ Prescription ☐ Other (please describe): ____________	

$ __________ **TOTAL Health Reimbursement Arrangement Requested**

***READ CAREFULLY:* 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.

EMPLOYEE'S SIGNATURE: (REQUIRED)		DATE:	

Did you know that you can….

- File your claim online
- Sign-up for direct deposit online
- Update your account information online

Visit us online at www.benstrat.com

Health Reimbursement Arrangement (HRA) Filing Instructions

Who is eligible?

- An employee who is enrolled in the Plan, and their dependents.

Examples of qualifying expenses

- Health Reimbursement Arrangements can be used to pay for any item that qualifies as a medical expense under the Internal Revenue Code, with the exception of long-term care. However, your employer determines which expenses are covered under your plan. Depending on your benefits, you may be eligible to submit copies of receipts for co-pays, deductibles, dental, vision or hearing expenses, prescriptions, and over the counter items (e.g. medical monitoring devices and diabetes supplies).
  Please Note: Legislation recently enacted a law that mandates some OTC expenses will no longer be eligible for reimbursement under health FSA effective January 1, 2011.

- Expenses must be incurred on or after your effective date for the plan year and before the end of the plan year (or grace period, if adopted by your employer). In accordance with the IRS rules, reimbursements will not be made until the services have been provided.

Please Note: The above eligibility and expense guidelines are intended for informational purposes only. For a description of how your plan works, please refer to the Summary Plan Description (SPD). The information contained in the SPD takes precedent over the guidelines in this form.

Documentation must show

- Receipt of office co-payments
- Invoice for your medical and/or dental expenses, which your insurance company does not cover
- Receipts for prescription
- Explanation of Benefit (EOB) statements from your insurance company, which show the amount or percentage of a medical or dental charge your insurance company paid and how much you must pay.

Please Note: Some items may require further documentation from your physician or healthcare provider. We will contact you if further documentation is required.

Please Note: Cancelled checks, credit card slips or statements showing only a balance forward are **not** accepted as valid receipts.

If you have any additional questions regarding your plan please contact us by phone at (603) 647-4666 or (888) 401-FLEX (3539). Visit us online at www.benstrat.com.