

# REQUEST FOR REIMBURSEMENT

Instructions: **FAILURE TO COMPLETE ALL SECTIONS OF THE FORM MAY DELAY THE PROCESSING OF YOUR CLAIM.** Please print or type the requested information. For all types of claims, complete Part I of the form. Complete Part II for any medical/dental/optical/over the counter type of expenses. Complete Part III for any dependent daycare expense. You **MUST** document each expense by either attaching itemized receipts or have the provider complete the provider certification section (daycare only). Attach copies (do not send originals) of the receipts for each expense showing who the service is for, the provider or store name, the incurred date (not paid date), the amount, and the nature of the expense. If you are submitting more than one expense, number the receipt copy to correspond to the line number on which the expense is listed. **Sign and date the form.** Please make a copy of this form for your records and send the original with attached receipts to:  
**Corporate Health Systems, Inc. Attn: Reimbursement Claims P.O. Box 46390 Eden Prairie, MN 55344-6390 or Fax to (952) 939-0990 ~ Phone (952) 939-0911**

## PART I EMPLOYEE INFORMATION

EMPLOYEE NAME \_\_\_\_\_ EMPLOYER NAME \_\_\_\_\_  
 Last 4 Digits of Social Security Number \_\_\_\_\_ Daytime Phone Number \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY / STATE / ZIP \_\_\_\_\_  CHECK IF NEW ADDRESS

## PART II MEDICAL / DENTAL / OPTICAL / OVER THE COUNTER EXPENSES

| LINE                           | PERSON RECEIVING SERVICE | PROVIDER'S NAME (Doctor, Dentist, Etc.)<br>OVER THE COUNTER PRODUCTS (Store Name) | SERVICE DATE<br>(Mo/DAY/YR) | REQUESTED<br>AMOUNT | NATURE OF EXPENSE<br>OR NAME OF PRODUCT | OFFICE<br>USE |
|--------------------------------|--------------------------|---|-----------------------------|---------------------|---|---------------|
| 1                              |                          |   |                             |                     |   |               |
| 2                              |                          |   |                             |                     |   |               |
| 3                              |                          |   |                             |                     |   |               |
| 4                              |                          |   |                             |                     |   |               |
| 5                              |                          |   |                             |                     |   |               |
| 6                              |                          |   |                             |                     |   |               |
| 7                              |                          |   |                             |                     |   |               |
| 8                              |                          |   |                             |                     |   |               |
| <b>TOTAL AMOUNT REQUESTED:</b> |                          |   |                             |                     |   |               |

## PART III DEPENDENT DAYCARE EXPENSES

| LINE                           | DEPENDENT'S NAME WHO IS<br>RECEIVING THE SERVICE | DAYCARE PROVIDER'S NAME | SERVICE DATE RANGE<br>(Mo/DAY/YR - Mo/DAY/YR) | REQUESTED<br>AMOUNT | AGE OF<br>DEPENDENT | PROVIDER'S CERTIFICATION OF CLAIM LINE<br>SIGNATURE AND EXPENSE AMOUNT | OFFICE<br>USE |
|--------------------------------|--|-------------------------|---|---------------------|---------------------|--|---------------|
| 1                              |  |                         |   |                     |                     | /\$  |               |
| 2                              |  |                         |   |                     |                     | /\$  |               |
| 3                              |  |                         |   |                     |                     | /\$  |               |
| 4                              |  |                         |   |                     |                     | /\$  |               |
| 5                              |  |                         |   |                     |                     | /\$  |               |
| <b>TOTAL AMOUNT REQUESTED:</b> |  |                         |   |                     |                     |  |               |

I certify the above information is correct and the expenses claimed were incurred by me or my eligible dependents after my effective date of coverage in my employer's reimbursement benefit plan but prior to the end of my employer's plan year. I certify these expenses are **not** eligible for reimbursement under any other plan, and comply with the requirements of this plan. I have not and will not claim these expenses on my personal income tax return. I certify, to the extent required by federal law, that I will file the designated form with the IRS by April 15 of the year after the expenses were incurred.

**EMPLOYEE SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_

## A REMINDER ABOUT REIMBURSABLE HEALTH CARE EXPENSES

See your Summary Plan Description for additional information.

1. You can use a Medical Reimbursement Account to get reimbursed for any eligible expenses not paid in full by another plan, or for any eligible expenses not covered by your health plan. **An eligible expense must meet the following requirements:**
  - Must be directed or prescribed by a physician, *except for* eligible over-the-counter products.
  - Must be directly related to a physical or mental condition.
  - Expenses must be incurred on or after the effective date of the plan and while you are a participating employee.
  - Expenses must be incurred for you, your spouse, or other person who qualifies as an eligible dependent for federal income tax purposes.
2. Examples of eligible expenses include:
  - Deductibles (the part of covered expenses you pay before your health plan pays any benefits).
  - Coinsurance amounts (the percent of covered expenses you must pay, if any, after the deductible requirement has been met).
  - Dental expenses, such as, exams or other accepted services.
  - Vision care expenses, such as, eye examinations and eyeglasses.
  - Hearing care expenses, including hearing examinations and hearing aids.
  - Routine physical examinations
  - Prescription medications
  - Certain over-the-counter products
3. You must furnish proof the expenses were incurred by attaching an itemized statement from the provider. If a statement is attached, please write the corresponding line number which the expense is listed (taken from column (1) on the front of the form).
4. HRA/VEBA Eligible Expenses (if applicable):

Eligible expenses are subject to your employer's HRA/VEBA Plan Document. See the HRA/VEBA plan document for a list of eligible expenses as they may differ from those listed above.

## A REMINDER ABOUT REIMBURSABLE DAY CARE EXPENSES

1. In order for your day care expenses to qualify for reimbursement from the Day Care Expense Account, the following requirements must be met:
  - If you are married, your spouse must be working for pay, attending school or seeking employment while you are at work.
  - The children receiving day care must be under the age of 13 at the time the day care services are provided, or the person receiving care must be physically or mentally incapable of self care.
  - The provider cannot be listed as a dependent on your federal income tax form, and, if the provider is your own child, must be at least 19 years of age.
  - Expenses must be incurred on or after the effective date of the plan and after the date you become a plan participant.
  - Under federal law, when you file your income tax return with the IRS you must also report the name, address, and taxpayer identification number of all providers of dependent day care services whose fees were reimbursed to you under this plan during the year. Failure to do so constitutes tax fraud **unless** the provider of these services is a 501(c) (3) tax-exempt organization. If you have questions on how this might affect your tax filing, refer them to your tax advisor.
2. If the amount of day care expense reimbursement you receive for a calendar year exceeds your earnings if you are single, or the earnings of the lower paid spouse if you are married, the difference must be reported as taxable income for the year. There are special rules if your spouse is a full time student or is physically or mentally incapable of self care. Again, see your tax or legal advisor.
3. You must furnish proof that the expenses were incurred **either** by having the provider complete the Certification of Provider Section of the form or by attaching an itemized statement from the provider. If a statement is attached, please write on that statement the line number (taken from column (1) from the front of the form) corresponding to that item of expense.
4. If there is not enough money in your Day Care Expense account to cover in full the eligible expenses listed on this form, you will be reimbursed up to the amount of your account balance. Additional reimbursements due you will be temporarily suspended. Suspended amounts will automatically be processed each time reimbursements are paid.