

Section 125 Flexible Benefits Plan Employee Reimbursement Request Form



1. Employee Information

Your Employer's Name _____

Your Name (Participant) _____ SSN _____ - _____ - _____ Daytime Phone _____

Street, City, State, Zip _____ Check if New Address Email Address (optional) _____

If your claim includes expenses incurred by a spouse or eligible dependents, please provide the following information:

Name	Relationship to Employee	Date of Birth	Social Security Number
_____	_____	_____	_____
_____	_____	_____	_____

2. Reimbursement Request

Please indicate your qualifying expenses for reimbursement below. **Do not include expenses reimbursed by any other source.** Attach bills, receipts, Explanation of Benefits summaries (EOBs) or other claim documentation. Documentation must include dates of service, description of service, provider's name and address and the expense amount. Cancelled checks are NOT sufficient proof of your claim. **Do not use this claim form if you have used your University of Louisville "Thinker" debit card to pay for the expense. You must complete the Debit Card Expense Substantiation Form for expenses that were paid with the University of Louisville "Thinker" card.** We will not be held responsible for any duplicate claims that have been submitted in error.

Health Care Spending Account - Please enter the following claim information:

Date Range of Service	Brief description of all attached receipts
From: _____	_____
To: _____	_____

Total Health Care Reimbursement Request \$



Dependent Care Spending Account - Please enter the following claim information:

Dates of Service	Provider's Name	Provider Tax ID or Social Sec #	Amount
_____	_____	_____	_____
_____	_____	_____	_____

Total Dependent Care Reimbursement Request

Dependent Care Provider's Signature: _____ **Date:** _____ \$



3. Claim Certification

I certify that these expenses for which reimbursement is claimed from the Employee Flexible Spending Account Program have been incurred by me, my spouse or my eligible dependent(s) and are not payable by any other benefit plan or program. I have not and will not itemize and deduct, nor claim credit for these expenses on my individual income tax returns.

Employee Signature: _____ Date: _____

(For office use only)

Claim # _____

Denial _____

Administrator Initials _____

Please submit this form along with supporting documentation to: CSA, 3510 Irwin-Simpson Road, Mason, OH 45040

Local Phone: (513) 459-9997	Toll-free phone: (800) 982-7715
Local Fax: (513) 459-9947	Toll-free fax: (888) 245-8452
Email: flex@chard-snyder.com	Website: www.chard-snyder.com

Employee Flexible Spending Account Program Claim Reimbursement Instructions

1. Complete all information in **Section 1** (please print or type). **Please include your e-mail address if you want to receive an automatic e-mail notification whenever a claim is processed.** If you have used your Flexible Spending Account **SMARTFLEX** debit card to pay for this expense, you cannot use this form. Instead, you must use the Debit Card Expense Substantiation Form to submit your claim.
2. Attach supporting documentation. Substantiation must accompany this request form in order for claims to be considered for reimbursement. Be sure to keep copies of receipts, bills, etc. for your records. Originals will not be returned. **All substantiation must include the following items to be eligible for reimbursement:**
 - Original **date** of service (not the date of payment)
 - **Type** of service performed (refer to list of eligible expenses to identify valid services)
 - Provider's **name** and address (and Tax ID / SSN for Dependent Care expenses)
 - **Amount** charged to you (do not include amounts reimbursed by another source)
3. For a **Healthcare Reimbursement Request**, complete all information in **Section 2** and attach proof of expense as described above. Sales tax is now includable in your total amount.
4. For a **Dependent Care Reimbursement Request**, complete all information in **Section 2** and attach proof of expense as described above unless provider's signature is included on the claim form.
5. Sign and date **Section 3**.
6. **Fax or mail** this form and supporting documentation directly to:

Chard, Snyder & Associates, Inc.
3510 Irwin-Simpson Road
Mason, OH 45040-9744

Toll-Free: (800) 982-7715
Fax: (513) 459-9947 or (888) 245-8452
E-Mail: flex@chard-snyder.com

7. **Important Reminders:**
 - Payments are issued after receipt and processing, subject to adjudication. **Transfer between accounts is prohibited.**
 - Any items for which you are reimbursed **cannot be claimed again** as deductions or credits on your individual tax return at the end of the tax year.
 - If a **Dependent Care** claim is submitted for an amount that is larger than the amount credited to your account, then payments will be issued according to the amount available. Anything requested above the available amount will "backlog" and will be released as additional credits are made to your account. **IRS Guidelines prohibit the advancement of Dependent Care Account funds.**
 - You may only be reimbursed for eligible expenses incurred **during** the current plan year. *Note: orthodontia expenses are reimbursed as designated by provider.*
 - Payment will be made to you, the participant, only. **Payments cannot be made to an alternate payee.**