Medical Deductible Reimbursement Plan Request

■ INSTRUCTIONS FOR SUBMITTING A CLAIM:

1. Complete Section A - Employee Information
2. Complete Section B - Claims and Expenses for Medical Deductible Reimbursement Plan Account. **Statements or invoices AND Explanation of Benefit Statement (EOB) from the insurance company are needed for reimbursement. Attach documentation describing the service(s) rendered, date of service (s), amount (s) paid, and for whom the service(s) were rendered.** (Such supporting documents become part of this claim and cannot be returned to you.)
3. Photocopies of forms and documents are acceptable. **Note: The IRS has determined that cancelled checks (for medical expenses), balance forward, previous balance statements or charge card receipt statements are not acceptable documentation of expenses.**
4. Fax or mail claim to: Plan Administrator
   Benefits Network, Inc.
   118 West Main Street, Suite 301
   Somerset, PA 15501
   Phone (814) 445-4943
   Direct (814) 289-4229
   Fax (814) 445-3295 *Email: ttirko@benefitsnetwork.biz*

SECTION A

Employer Name: _____

Employee Name: _____ **Last 4 Digits of SS#** _____

Address: _____ **Is this a new address? ____Yes ____No**

City: _____ **State:** _____ **Zip:** _____ **Phone:** _____

SECTION B — Eligible Medical Expenses

Name and Relationship (i.e. Self | Spouse | Dependent)	Date of Birth	Date(s) of Service From To	Description of Service	Dollar Amount
1.		-		$
2.		-		$
3.		-		$
4.		-		$
5.		-		$
6.		-		$
			Request Total:	$

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 eligible expenses incurred during the applicable plan year for my eligible dependents and myself. I certify that these expenses have not been and will not be reimbursed under any other employer sponsored benefit plan (including any HSA) and will not be claimed as an income tax deduction. In addition, I certify that these expenses have not been previously reimbursed under this plan. I understand and authorize that my plan account will be reduced by the amount of the requested reimbursement.

Employee's Signature: _____ ***Date:*** _____

Reminders: Provide complete and proper documentation for all expenses submitted.

Keep copies of everything submitted for reimbursement.

All rejected claims must be resubmitted.