Company:_____
(required)

BENEFIT MANAGERS COMPANY
REIMBURSEMENT REQUEST FORM

Employee Name: _____ **SSN:**_____
(optional)

Please select which of the following accounts you would like reimbursement from:

$_____ Medical FSA $_____ Dependent Care FSA

$_____ Health Reimbursement Account $_____ Bridge HRA (buydown)

Proof of expense is required for reimbursement. Incomplete or undocumented requests will not be reimbursed.

Each Medical FSA and HRA claim must clearly indicate:

1. Date services were incurred
2. Provider's name
3. Patient's name
4. Procedures provided
5. Amount of patient's responsibility
6. Over the counter receipts must identify product and date of purchase. All OTC drugs must be accompanied by a statement of medical necessity or prescription.

Each Dependent Care FSA claim must clearly indicate:

1. Provider's name
2. Dependent's name
3. Date of service
4. Amount due provider

Bridge HRA claims must include an Explanation of Benefits.

My signature below attests that I have read and understand the requirements for submitting a claim and the reimbursement being requested is: for a qualified participant (myself, spouse or dependent); (b) has been incurred as eligible; (c) qualifies as medical care under Code § 213(d) (is not for cosmetic purposes, general health purposes or toiletries); (d) has not previously been reimbursed (and will not be reimbursed) from any other health plan coverage; and (e) will not be used to claim any other deduction.

_____ _____
Employee Signature Date

Change of Address or Phone Number?

Street: _____

City/State/Zip _____

Phone: _____

Please mail or FAX this form and receipts to:

Benefit Managers Company
P.O. Box 190840
Boise ID 83719
FAX: 208-672-8330 or 1 (888) 672-8330
Questions: call: 208-322-6546