# Healthcare and Dependent Care Claim Form Instructions Bulletin

#### REQUEST FOR REIMBURSEMENT

Prompt claim processing is largely dependent on the submittal of a properly completed Request for Reimbursement form (Health Care -vs.- Dependent Care Reimbursement). A properly completed form includes:

Legible personal information (employee name, social security number & current address)
Employer Name (when not using a pre-printed form from your HR office)
A marked change of address box, if applicable
Legible claim description and expense information
A legible, itemized statement and/or receipts from your provider
An Explanation of Benefits (EOB) from all health insurance carriers
Claim total
Employee SIGNATURE
A separate claim form for each plan year

## CLAIM PROCESSING TIMELINES

Properly completed Request for Reimbursement forms received 72 hours before your plans' scheduled check-printing date will be processed in that check run. If you submit your claim request via facsimile, the deadline is 1:00 p.m. before the 72-hour cutoff. For example, if your plans' check printing date is Friday, the check run will include all forms received by 1:00 p.m. on Tuesday. If your Request for Reimbursement is incomplete, it's processing may be delayed until the matter is resolved.

Please retain a copy of your Request for Reimbursement Form, along with all supporting documentation for your itemized expenses.

#### CHECK STOP PAYMENT AND/OR CHECK REISSUE REQUESTS

Benefit Administration Company (BAC) will process check stop payment and/or reissue according to the following guidelines:

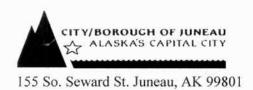
	All stop payment requests will be held for a minimum waiting period of ten business days from the
II PTO	original check release date.  Once BAC has placed the stop payment with the financial institution, the reissued check will be held
ш	for 2 business days in accordance with the financial institution's requirement.
	A \$30 processing fee will apply for all stop payment/reissued checks not resulting from a BAC error
	BAC will issue a replacement check for a damaged original check only after the original check has
	been returned to BAC

#### OTHER HELPFUL HINTS

- Eligible expenses are determined by the date of service, NOT the date the payment is made to the provider. Therefore, cancelled checks, bank statements, credit card receipts and provider balance forward statements are not acceptable documentation.
- > A Dependent Care claim may be submitted up to 3 months in advance of services rendered
- > Once the plan year has begun, you may only change your elected annual contribution amount if you have a change in family status (see your Summary Plan Description for more details).
- > IRS rules require that the balance remaining in your reimbursement account (healthcare and/or dependent care) be forfeited at the end of the plan year.

### EXAMPLES OF EXPENSES NOT ELIGIBLE FOR REIMBURSEMENT

- > Health Care Spending Account: weight loss programs unless prescribed to treat a specific medical condition; cosmetic surgery; teeth bleaching, custodial care (nursing home)
- Dependent Care Spending Account: overnight camp, diapers, late payment charges and care provided while you or your spouse are not working



# REQUEST FOR REIMBURSEMENT HEALTH CARE CLAIM FORM

Employee (Las	st Name, First Name, Middle Init.)		Social Security Number		
Address	4	()	Please be sure to staple documentation of services provided to the back of this claim form. Acceptable documentation is: 1) Explanation of Benefits (EOB) from the insurance company; 2) statement or bill from the health care provider that shows date		
City State		Zip	of service and your financial responsibility; or 3) for contact lens supplies and co-payments only, a receipt.		
Daytime Phone	e (very important)	re if address change	To be eligible for reimbursement, a health care expense must be for you, your legal spouse, or dependent as defined by the IRS. Furthermore, the expense must be for services performed during the plan year, and not be covered by any other health insurance (i.e. an out-of-pocket expense).		
Fill in the inform or bill or copy o expense. NOTE	nation below for health care expenses inc f your receipt or bill stating the <u>DATE OF</u> E: Expenses covered under a medical, o I OF BENEFITS YOU RECEIVED FROM	SERVICE. Do not atta dental, vision or hearing	ch receipts or bills plan must be sub	s, which do not identify your expense mitted under that plan first ATTAC	e as a health care
Date Expense Incurred	Name & Relationship of Person Incurring Expense	Description of Service/Expense		Name of Service Provider	Your Unreimbursed Expense
					s
				******	
				- Harris - Russian - Lands	
		TOTA	AL Medical Care	Expense Claim:	\$
I certify that I are	N BY THE PLAN PARTICIPANT In responsible for the validity of this clain urther certify that I have not and will not	im and that the expens t claim the listed exper	ses listed are not nses as an incom	eligible for further reimbursement e tax deduction.	t under any other
Signature of Pa	articipant			Date	
SEND COMPLETE	ED CLAIM FORM TO:	Benefit Administration P.O. Box 550 Seattle, WA 98111 (206) 625-1800 or (8	-0550		
OR, FAX CLAIM F (Note: If faxing cl	FORM TO: laim <b>do not</b> mail original.)	(206) 682-8016 (FAX	X)		

PLEASE KEEP A COPY OF ALL SUBMITTED CLAIMS AND DOCUMENTATION. A FEE MAY BE CHARGED FOR REQUESTED COPIES.

