**REQUEST FOR REIMBURSEMENT**

**HEALTH CARE**

Use this form for submitting manual receipts for Medical, Dental, Vision, Prescriptions and Over-the-Counter expenses

---

**EMPLOYER NAME**

---

**INSTRUCTIONS**

Fill in the information below for health care expenses incurred by you or your eligible dependent for which you request payment. A copy of your receipt or bill stating the DATE OF SERVICE must accompany each expense item. Do not attach receipts or bills that do not identify your expense as a health care expense. NOTE: Expenses covered under a medical, dental, vision or hearing plan must be submitted under that plan first. A COPY OF THE EXPLANATION OF BENEFITS YOU RECEIVE FROM YOUR INSURER IS IDEAL. Please keep a copy for your records.

---

<table>
<thead>
<tr>
<th>Date Expense Incurred</th>
<th>Name &amp; Relationship of Person Incurring Expense</th>
<th>Description of Service/Expense</th>
<th>Name of Service Provider</th>
<th>Your Unreimbursed Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL Health Care Expense Claim: $ ____________

---

**CERTIFICATION BY THE PLAN PARTICIPANT**

I certify that I am responsible for the validity of this claim and that the expenses listed are not eligible for further reimbursement under any other health plan. I further certify that I have not and will not claim the listed expenses as an income tax deduction.

Signature of Participant ___________________________ Date ____________

SEND COMPLETED CLAIM FORM TO: Benefit Administration Company OR, EMAIL SIGNED CLAIM FORM TO: flexcs@baclink.com

P.O. Box 550 Seattle, WA 98111-0550 www.baclink.com

(206) 625-1800 or (800) 967-3709

OR, FAX CLAIM FORM TO: (206) 682-8016 (FAX)

(Note: If faxing claim do not mail original.)

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

YOU SHOULD RETAIN RECEIPTS FOR SEVEN YEARS FOR INCOME TAX PURPOSES.

---
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 original check release date.
- Once BAC has placed the stop payment with the financial institution, the reissued check will be held 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