B·D·S
BENEFIT DESIGN SPECIALISTS, INC.
AN ALERA GROUP COMPANY

Request for Reimbursement Claim Form

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Employer Name:					**Email:**	
Employee Name:	Last	First		MI	**Last 4 of SSN**	XXX-XX-
Employee Address:	Street	City	State	Zip	**Phone#**	

☐ **Please check if this is a new address**

MERP™ Plan

Date of Service MM/DD/YY	Patient Name	Name of Provider	Phone Number of Provider

☐ Please process any/all portion(s) of my MERP deductible responsibility through my FSA account
* The FSA portion of this form does not have to be completed if this box is checked

FSA Medical Expense Claims

Please list below (or on an attached statement) all FSA claims that require a reimbursement. Claims not listed will not be processed

Paid by Summit Card	Date of Service	Patient Name	Relationship	Name of Provider	Description of Service	Claim Amount
☐ Yes ☐ No						
☐ Yes ☐ No						
☐ Yes ☐ No						

FSA Dependent Care Claims

Date of Service From	To	Dependent Name	Age	Dependent Care Provider Name	Dependent Care Provider Address	Provider Tax ID#/ SS#	Claim Amount

HSA Plan

Please Process My Request As Follows (Select One):

☐ **No Reimbursement Requested – Please only enter my claims in the Claim Vault, I understand I may request payment in the future.**
☐ **Yes, Reimbursement Requested – Please enter my claims in the Claim Vault and process a Direct Deposit distribution.**
☐ **Reimbursement Only – No Claims to Submit to the Claim Vault at this time.**

Reason For Distribution (Select One):

☐ **Normal Qualified Distribution**
☐ **Non-Qualified Distribution**
☐ **Disability/Death**
☐ **Withdrawal of Excess Contributions & Earnings**
☐ **Close Account and Distribute Remaining Balance**
☐ **Other**

Amount Requested for Distribution

Distribution Method

☐ **Direct Deposit**
☐ **Mail Check** ($3.00 Charge/Check)

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. Receipts from my service provider(s) for all expenses are attached to this voucher. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable underlaw.

Employee Signature:_____ **Date:**____/____/____

****There is a specific time limit each plan year that your claims can be submitted for reimbursement. Please refer to your Summary Plan Description for specific claims run-out information.**

Mail To: Benefit Design Specialists, Inc.
Attn: Claims Department
4550 Lena Drive
Mechanicsburg, PA 17055

Questions: 888-273-7036

or FAX To: 855-289-2602
or E-MAIL To: Claims@bdsadmin.com