



Request for Reimbursement Claim Form

Page ____ of ____

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

Please read the Reimbursement Account Rules and Claim Filing Instructions before completing this claim

*Information below must be completed

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

HSA Plan	
<p>Please Process My Request As Follows (Select One):</p> <div style="display: flex; justify-content: space-between;"> <div> <p><input type="checkbox"/> No Reimbursement Requested – Please only enter my claims in the Claim Vault, I understand I may request payment in the future.</p> <p><input type="checkbox"/> Yes, Reimbursement Requested – Please enter my claims in the Claim Vault and process a Direct Deposit distribution.</p> <p><input type="checkbox"/> Reimbursement Only – No Claims to Submit to the Claim Vault at this time.</p> </div> <div> <p><input type="checkbox"/> Amount Requested For Distribution _____ (Select One)</p> <p><input type="checkbox"/> Direct Deposit Into Personal Checking Account on File</p> <p><input type="checkbox"/> Mail Check To Me (a fee of \$3.00 for each paper check will apply)</p> </div> </div> <p>Reason For Distribution (Select One):</p> <p><input type="checkbox"/> Normal Qualified Distribution</p> <p><input type="checkbox"/> Non-Qualified Distribution</p> <p><input type="checkbox"/> Disability/Death</p> <p><input type="checkbox"/> Withdrawal of Excess Contributions & Earnings</p> <p><input type="checkbox"/> Close Account and Distribute Remaining Balance</p> <p><input type="checkbox"/> Other</p>	

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 under law.

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: 717-766-8844

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