B·D·S
BENEFIT DESIGN SPECIALISTS, INC.

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

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

Date of Service MM/DD/YY	Patient Name	Relationship	Name of Provider	Description of Service	Claim Amount

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
1 Kacey Court, Suite 100
Mechanicsburg, PA 17055

Questions: 717-766-8844

or FAX To: 855-296-1027
or E-MAIL To: Claims@bdsadmin.com